PPACA PULSE CHECK

HEARING

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

AUGUST 1, 2013

Serial No. 113–78

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

87–165 PDF WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

FRED UPTON, Michigan
Chairman

RALPH M. HALL, Texas
JOE BARTON, Texas
Chairman Emeritus
ED WHITFIELD, Kentucky
JOHN SHIMKUS, Illinois
JOSEPH R. PITTS, Pennsylvania
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE ROGERS, Michigan
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
Vice Chairman
PHIL GINGREY, Georgia
STEVE SCALISE, Louisiana
ROBERT E. LATTA, Ohio
CATHY MCMORRIS RODGERS, Washington
GREGG HARPER, Mississippi
LEONARD LANCE, New Jersey
BILL CASSIDY, Louisiana
BRETT GUTHRIE, Kentucky
PETE OLSON, Texas
DAVID B. MCKINLEY, West Virginia
CORY GARDNER, Colorado
MIKE POMPEO, Kansas
ADAM KINZINGER, Illinois
H. MORGAN GRIFFITH, Virginia
GUS M. BILIRAKIS, Florida
BILL JOHNSON, Ohio
BILLY LONG, Missouri
RENEE L. ELLMERS, North Carolina

HENRY A. WAXMAN, California
Ranking Member
JOHN D. DINGELL, Michigan
FRANK PALLONE, JR., New Jersey
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANICE D. SCHAKOWSKY, Illinois
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
JOHN BARROW, Georgia
DORIS O. MATSUI, California
DONNA M. CHRISTENSEN, Virgin Islands
KATHY CASTOR, Florida
JOHN P. SARBANES, Maryland
JERRY MCNERNEY, California
BRUCE L. BRALEY, Iowa
PETER WELCH, Vermont
BEN RAY LUJAN, New Mexico
PAUL TONKO, New York

C O N T E N T S

PPACA PULSE CHECK

THURSDAY, AUGUST 1, 2013

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
WASHINGTON, DC.

The committee met, pursuant to call, at 10:05 a.m., in Room 2123, Rayburn House Office Building, Hon. Marsha Blackburn (vice chairman of the committee) presiding.

Members present: Representatives Upton, Hall, Barton, Whitfield, Shimkus, Pitts, Terry, Murphy, Burgess, Blackburn, Gingrey, Scalise, Latta, Harper, Lance, Cassidy, Guthrie, Olson, Gardner, Pompeo, Kinzinger, Griffith, Bilirakis, Johnson, Long, Ellmers, Waxman, Dingell, Rush, Eshoo, Engel, Green, DeGette, Schakowsky, Barrow, Matsui, Christensen, Castor, Sarbanes, and Tonko.

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Megan Capiak, Staff Assistant; Karen Christian, Chief Counsel, Oversight and Investigations; Noelle Clemente, Press Secretary; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Sydne Harwick, Legislative Clerk; Brittany Havens, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Kirby Howard, Legislative Clerk; Nick Magallanes, Policy Coordinator, Commerce, Manufacturing, and Trade; Carly McWilliams, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Krista Rosenthall, Counsel to Chairman Emeritus; Heidi Stirrup, Policy Coordinator, Health; Tom Wilbur, Digital Media Advisor; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Alli Corr, Democratic Policy Analyst; Hannah Green, Democratic Staff Assistant; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Staff Director; and Stephen Salsbury, Democratic Special Assistant.

Mrs. BLACKBURN. The committee will come to order. The Chair recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

As we prepare to return to our districts for the August work period, there is one topic of conversation that will be sure to arise

whether I am in Williamson, Montgomery, or Henderson Counties, all areas that are familiar and known to our witness today. Of the folks I hear from most when it comes to Obamacare, I would say that they are probably in two camps: those who aren't quite sure what Obamacare will mean for them and their families, and those who have studied the law and its policies and are opposed to what it will do.

It is the uncertainty of the law that most concerns me: uncertainty about how much individuals' health insurance costs are going up to comply with the laws and the mandates and the taxes; uncertainty about what new and additional expenses employers must take on as a result of the law; and business uncertainty for the numerous medical device companies that call Tennessee home due to the medical device tax.

It appears you have a lot of work to do by October 1 and the end of the year, so much so that Secretary Sebelius even acknowledged having—and I am quoting her—"very tight deadlines."

I voted yes on the Fairness for American Families Act earlier this month to delay the individual mandate for 1 year, a mandate supported by just 12 percent of the Americans. Despite being told over and over by the President that if you like what you have you can keep it, and that healthcare premiums would go down on average $2500, individuals in Tennessee are seeing the opposite. Based on the exhaustive work by our staff here at committee, our report found that for those in the individual market in Tennessee, premium increases of 49 to 54 percent could be expected, as well as increases of 35 percent in the small group market.

Unfortunately, these increases should surprise no one. If something is taxed, and there is $165 billion in taxes and fees on health plans, plans sold on the Federal exchanges, drug manufacturers, and medical devices, and then loaded down with mandates, which guaranteed issue, community rating, essential health benefit requirements, it is absolutely going to be more expensive.

According to a recent Gallup Poll, more than 40 percent of the small business owners have frozen hiring, 19 percent have reduced the number of employees, and 9 percent of the over 600 employers surveyed say that Obamacare would be good for their business, as opposed to 48 percent that say it would be bad.

[The prepared statement of Mrs. Blackburn follows:]

PREPARED STATEMENT OF HON. MARSHA BLACKBURN

As we prepare to return to our districts for the August work period, there is one topic of conversation that will be sure to arise whether I am in Williamson, Montgomery. or Henderson County.

Of the folks I hear from most when it comes to Obamacare, I'd say there are two camps—those who aren't quite sure what Obamacare will mean for them and their families, and those who have studied the law and its policies and are opposed to what it will do.

It is the uncertainty of the law that most concerns me.

Uncertainty about how much individual's health insurance costs are going up to comply with the law's mandates and taxes.

Uncertainty about what new and additional expenses employers must take on as a result of the law.

And business uncertainty for the numerous medical device companies that call Tennessee home due to the medical device tax.

It appears you have a lot of work to do by October 1 and the end of the year—so much so that Secretary Sebelius even acknowledged having "very tight deadlines."

I voted yes on the Fairness for American Families act earlier this month to delay the individual mandate for one year—a mandate supported by just 12 percent of Americans.

Despite being told over and over by the president that "if you like what you have you can keep it" and that health care premiums would go down by an average of $2,500, individuals in Tennessee are seeing just the opposite.

Based on the exhaustive work by our staff here at committee, our report found that for those in the individual market in Tennessee, premium increases of 49–54 percent could be expected, as well as increases of 35 percent in the small group market.

Unfortunately, these increases should surprise no one. If something is taxed and loaded down with mandates, it's going to be more expensive.

According to a recent Gallup poll, more than 40 percent of small-business owners have frozen hiring.

Another 19 percent have "reduced the number of employees [they] have in [their] business as a specific result of the Affordable Care Act [Obamacare]."

Finally, just 9 percent of the over 600 employers surveyed said that Obamacare will be good for their business compared to 48 percent who said it will be bad.

This is why the House voted to join President Obama in delaying the employer mandate reporting requirements earlier this month.

So, Administrator Tavenner, we thank you for coming before us today. We look forward to your testimony and for a chance to expand on some of these issues during question and answer.

Mrs. BLACKBURN. At this time, I yield my remaining time to the chairman of the full committee, Mr. Upton.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you very much.

You know, for more than 3 years we have heard mounting confusion and concern about how the healthcare law will impact coverage and costs for families and job creators. We have heard about the law's red tape that has stifled job creation and threatened existing healthcare coverage for millions. And with just 60 days left until enrollment begins my constituents want clear answers on the law's true costs. What will premiums look like for millions of Americans who thought they would be able to keep their current plan if they liked it? How much will American taxpayers spend over the next 10 years? And what assurances are in place to ensure that taxpayer dollars are, in fact, protected?

Will businesses stop hiring full-time employees? And are we in a permanent transition to a part-time economy? I met with a number of my small businesses earlier this week, and the healthcare law has been a mess for our job creators from top to bottom.

Finally, with 2 months left until open enrollment in the exchange begins, is HHS really ready? The recent decision by the administration to delay the employer mandate less than 6 months before full implementation makes us wonder if HHS is planning other delays or changes to the law as well. The decision raises serious questions about the administration's ability to implement the law and the authority to rewrite it, questions that the Treasury Department did not sufficiently answer last week.

The public's anxiety is real, and it is escalating every day, especially as they are left behind to endure the looming premium rate shock while businesses are shielded from reporting and penalties.

The President made a lot of promises to the American people, both before and after the law's passage, and the promises to make health care more affordable and more accessible have fallen woefully short.

This hearing will provide an opportunity to further check on the status of those promises. This committee has conducted ongoing oversight of the law's implementation. Since January of 2011, we have held dozens of hearings to ensure that the American public indeed has the information that they need, and today is no different. With the clock ticking, it is time for the administration to keep its promises of transparency.

I appreciate you being here today, and our constituents are seeking real information. We look forward to getting those answers. And I yield back.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

For more than three years, we have heard mounting confusion and concern about how the health care law will impact coverage and costs for families and job creators. We have also heard about the law's red tape that has stifled job creation and threatened existing health care coverage for millions of Americans.

With just 60 days left until enrollment begins, my constituents want clear answers on the law's true costs. What will premiums look like for millions of Americans who thought they would be able to keep their current plan if they liked it? How much will American taxpayers spend over the next 10 years and what assurances are in place to ensure taxpayer dollars are protected? Will businesses stop hiring full-time employees and are we in a permanent transition to a part-time economy? I met with a number of my small businesses on Monday and the health law has been a mess for our job creators from top to bottom. Finally, with two months left until open enrollment in the exchanges begins, is HHS truly ready?

The recent decision by the administration to delay the employer mandate less than six months before full implementation makes us wonder if HHS is planning other delays or changes to the law. This decision raised serious questions about the administration's ability to implement this law and its authority to rewrite it—questions that the Treasury department did not sufficiently answer last week. The public's anxiety is real and escalating by the day, especially as they are left behind to endure the looming premium rate shock while businesses are shielded from reporting and penalties.

The president made a lot of promises to the American people both before and after the law's passage-and the promises to make health care more affordable and more accessible have fallen woefully short. This hearing provides an opportunity to further check on the status of those promises.

This committee has conducted ongoing oversight of the law's implementation and since January of 2011; we have held dozens of hearings to ensure the American public has the information they need, and today is no different.

With the clock ticking, it's time for the administration to keep its promises of transparency. Dodging simple questions like we saw last week will not work for our constituents who are already struggling with a flawed implementation.

Administrator Tavenner, your office agreed you would be available and willing to answer any and all questions related to the health care law. Thank you. Our constituents are desperate for information, and with 60 days left, there is no time left except for honest answers.

Mrs. BLACKBURN. Gentleman yields back.

At this time I recognize Mr. Waxman for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Madam Chair.

I am pleased to welcome Administrator Tavenner to our hearing today. She comes before this committee with an impressive record of achievement in both the public and private sectors, and she was recently confirmed by a huge bipartisan majority in the United States Senate. And we are delighted to have you here.

Four years ago, this committee was voting to report out of the committee and onto the House floor the Affordable Care Act. We were in markup for days and had heard testimony from dozens of witnesses. They described a system with rapidly rising costs, gross inefficiencies, and painful inequalities. We heard how those most in need of coverage—people who were ill, injured, or born with pre-existing conditions—were not able to purchase quality health insurance.

So we passed the Affordable Care Act to address these chronic problems in our healthcare system. We incorporated an individual responsibility requirement, championed by such conservative groups as the Heritage Foundation, and put in place in the State of Massachusetts by Governor Romney; we created a system that built upon the existing private sector insurance system; and used the same free market model that President Bush created when he signed into law the Medicare Part D program. We eliminated Medicare waste, fraud, and abuse, and we made sure our legislation reduced the deficit.

The Affordable Care Act deserved bipartisan support, but we faced united opposition from Republicans in the Congress who did not want to give President Obama a victory. And since then the law has become the Republicans' great white whale. They will stop at nothing to kill it.

Madam Chair, I would like to enter into the record a memorandum released by my staff this morning that provides more detail on the Republican efforts to ensure that healthcare reform is a failure.

Mrs. BLACKBURN. Without objection, it will be submitted.

[The information follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

August 1, 2013

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Ten Ways Republicans Have Acted to Undermine the Affordable Care Act

Republican leaders fought the passage of the Affordable Care Act in Congress; they were outvoted. Republican attorneys general continued the fight in the courts; they lost when the Supreme Court upheld the law. The National Republican Party tried to make the 2012 elections a referendum on health reform; President Obama won handily. It is now clear that the Affordable Care Act will remain the law of the land. The Act's health care marketplaces that guarantee affordable and accessible health insurance coverage will open for enrollment on October 1, 2013.

In response, Republican leaders at the state and federal levels have acted in an unprecedented fashion to undermine the Affordable Care Act and ensure that it is a failure. Nonpartisan analysts have accused Republicans of trying to "sabotage" the law.

This memorandum describes ten ways that Republicans have acted to undermine the Affordable Care Act. These actions have, in several cases, run counter to long-standing Republican doctrines such as favoring state action to federal control. These obstructionist policies will prevent millions of their poorest constituents from receiving health insurance coverage. They will also mean higher costs for taxpayers in their states. And Republicans have taken these actions while failing to provide any legislative alternatives to provide the uninsured with health insurance coverage.

Republican leaders have acted to undermine the Affordable Care Act by:

- **Casting 40 votes to repeal the law**, futile efforts that have done nothing but create uncertainty and confusion in the mind of the public about the law's implementation.

- **Refusing to expand Medicaid coverage in over 20 states**, preventing millions of Americans from receiving health insurance coverage.
- **Refusing to establish state-based health insurance marketplaces**, complicating HHS efforts to implement the law and "increas[ing] federal involvement in ... state affairs."[1]
- **Undermining enrollment in health insurance marketplaces** via a multimillion-dollar campaign to "dissuade uninsured Americans from obtaining health coverage."[2]
- **Refusing to provide funding requested by the Obama Administration to implement the law.**
- **Attacking efforts to educate the public about the Affordable Care Act.**
- **Intimidating potential participants in public education efforts about the law.**
- **Insisting that the Affordable Care Act be defunded as a condition of preventing a government shutdown.**
- **Threatening to deny basic, Affordable Care Act-related constituent service requests from citizens** who request help with understanding or signing up for health insurance benefits under the law.
- **Misinforming citizens about the impact of health care reform on insurance premiums**, leading many to believe that premiums will skyrocket by failing to provide accurate assessments of the true costs in 2014.

Respected, nonpartisan analyst Norm Ornstein reached the following conclusion with regard to these Republican efforts, writing:

> What is going on now to sabotage Obamacare is ... sharply beneath any reasonable standards of elected officials with the fiduciary responsibility of governing. ... [T]o do everything possible to undercut and destroy its implementation -- which in this case means finding ways to deny coverage to many who lack any health insurance; to keep millions who might be able to get better and cheaper coverage in the dark about their new options; to create disruption for the health providers who are trying to implement the law, including insurers, hospitals, and physicians; to threaten the even greater disruption via a government shutdown or breach of the debt limit in order to blackmail the president into abandoning the law; and to hope to benefit politically from all the resulting turmoil -- is simply unacceptable, even contemptible. ... That the effort is spearheaded by the Republican leaders of the House and Senate ... takes one's breath away.[3]

---

[1]Office of Gov. Butch Otter, Health Insurance Exchange Myth, Fact (Jan. 18, 2013) (online at www.cdapress.com/news/local_news/article_d4bea2c6-619f-11e2-9e5b-001a4bcf887a.html).

[2]*Republicans Prepare for 'Obamacare' Showdown, With Eye to 2014 Elections*, Reuters (July 25, 2013) (online at www.reuters.com/article/2013/07/25/us-usa-healthcare-republicans-idUSBRE96O0EJ20130725).

[3]*The Unprecedented, Contemptible GOP Quest to Sabotage Obamacare*, Norm Ornstein, The Atlantic (July 25, 2013) (online at www.theatlantic.com/politics/archive/2013/07/the-unprecedented-contemptible-gop-quest-to-sabotage-obamacare/278098/).

I. INTRODUCTION

Republican members of Congress have opposed the Affordable Care Act since its passage in March 2010, and they have repeatedly tried and failed to repeal the law. Despite these repeated failures, they are now trying to undermine the implementation of the health care law.

Political analyst Chuck Todd accused Republicans of "trying to sabotage the law."[4] A *USA Today* editorial stated:

> Having lost in Congress and in court, they're now using the most cynical of tactics: trying to make the law fail. Never mind the public inconvenience and human misery that will result.[5]

These actions stand in stark contrast to the actions of Democratic members of Congress after passage of the 2003 Medicare Part D law. Most House Democrats opposed this law and were concerned about the process by which it was passed. They objected to the unprecedented three-hour House roll call vote; they protested when they learned that the Republican House Majority Leader offered political favors in exchange for votes; and they felt misled when they learned that a Bush Administration official threatened to fire a government actuary if he provided accurate cost estimates to Congress. But despite these concerns, Democratic members ultimately worked hard to ensure that the Part D bill was a success.

The Republican approach is different, relying on failure of the law rather than constructive changes. One analyst describes this approach in the following way:

> The GOP really, truly hates Obamacare. They believe that their best chance to repeal it is to make it as big a mess as possible. Anything that makes it easier to live with makes it harder to get rid of. … [T]his is a theory that requires Republicans to knowingly damage America's health-care system on the off-chance the damage is severe enough to help them accomplish a much larger policy goal. It's a theory that requires them to choose to let problems fester because the pain is more politically useful than the cure.[6]

---

[4] *Sabotage Governing*, The Washington Post (July 9, 2013) (online at www.washingtonpost.com/blogs/plum-line/wp/2013/07/09/sabotage-governing/).

[5] *GOP Poisons ObamaCare, Then Claims Its Sick*, USA Today (July 9, 2013) (online at www.usatoday.com/story/opinion/2013/07/09/affordable-care-act-obamacare-nfl-editorials-debates/2504207/).

[6] *Wonkbook: The GOP's Dangerous Obamacare Strategy*, Washington Post (May 28, 2013) (online at www.washingtonpost.com/blogs/wonkblog/wp/2013/05/28/wonkbook-the-gops-dangerous-obamacare-strategy/).

II. REPUBLICAN EFFORTS TO UNDERMINE AND SABOTAGE THE AFFORDABLE CARE ACT

A. 40 Votes to Repeal the Affordable Care Act

After this week, House Republicans will have voted 40 times to repeal or defund Obamacare. These votes began when Republicans took control of the House of Representatives in 2011; they continued after the November 2012 election when President Obama's reelection made repeal unrealistic.

Although the Republican repeal bills have no chance of passage, they do generate confusion, which may be their purpose. One analyst explained:

> This slew of three dozen repeal votes have changed both how the Affordable Care Act works and how the public perceives it. ... [T]he Kaiser Family Foundation polled Americans on whether the Affordable Care Act is still law. Twelve percent of Americans — that's about one in eight people — think that Congress repealed the Affordable Care Act. Another 23 percent aren't sure or refused to answer the question. Congress' repeal votes get media attention and coverage, which probably explains where these numbers come from. After hearing so much about congressional repeal, it's hard to blame Americans who think that the efforts have succeeded. The uncertainty that these repeal votes have created can have real consequences for the Affordable Care Act. ... It's easy to write off the repeal votes as inconsequential but, from a policy standpoint they're not. They've effected what the Affordable Care Act looks like nationally and locally in ways that will matter for years to come.[7]

B. Republican Governors' and State Legislatures' Refusal to Expand Medicaid Coverage

The Affordable Care Act provided for an expansion of the Medicaid program that was designed to help millions of low-income Americans receive health care coverage. Under this provision, states could cover individuals with incomes of up to 133% of the Federal Poverty Level, with the federal government reimbursing states for all of the costs for the first three years and then covering 90% of the costs in 2020 and beyond. The Congressional Budget Office (CBO) estimated that approximately 15 million low-income citizens would receive coverage as a result of this expansion.

---

[7] *Yes, the 37th Obamacare Repeal Vote Matters*, Washington Post (May 16, 2013) (online at www.washingtonpost.com/blogs/wonkblog/wp/2013/05/16/yes-the-37th-obamacare-repeal-vote-matters/).

However, in June 2012, the Supreme Court ruled that states could opt out of the Medicaid expansion. Twenty-one states – all with Republican governors or Republican-controlled legislatures – have chosen to take this route and opt not to expand their programs.[8]

The impact of these decisions is to deny 6.4 million Americans health coverage in a particularly unfair fashion by blocking some of the poorest Americans from obtaining coverage.[9] Under the Affordable Care Act, individuals with incomes above 100% of the Federal Poverty Level have the option of receiving coverage through the health insurance marketplaces, where they can qualify for tax credits and subsidies to ensure that coverage is affordable. But this option is not available to those with incomes below 100% of the Federal Poverty Level. Their only option for coverage is through Medicaid. In the states that are refusing to expand Medicaid, these very low-income individuals will be stranded without health insurance coverage. They will be unable to receive coverage through their state Medicaid programs or through the marketplaces.

Republican governors have described these decisions under the guise of financial responsibility. Texas Governor Rick Perry, a Republican, stated that "it would benefit no one in our states to see ... our economy crushed as our budget crumbled under the weight of oppressive Medicaid costs."[10] But nonpartisan analysts have concluded that expanding Medicaid would be the more fiscally responsible policy for the states because it would be almost entirely federally funded and would reduce the costs imposed on states, localities, and healthcare providers for uncompensated care for the uninsured, and increase state tax revenues. An analysis by the Rand Corporation concluded that states and localities opting out of the Medicaid expansion would spend more than $1 billion a year paying for the costs of uncompensated care. The study concluded that "it's in the best economic interests of states to expand Medicaid under the terms of the federal Affordable Care Act. Choosing to not expand Medicaid may turn out to be the more costly path for state and local governments."[11]

---

[8] Of the 21 states that have not expanded the Medicaid program, 19 have Republican governors. In Missouri and Montana, Democratic Governors Jay Nixon and Steve Bullock supported Medicaid expansion but were blocked from doing so by Republican-controlled state legislatures. (*Vote that Killed Medicaid Bill Was a Mistake, Lawmaker Says*, The Missoulian (Apr. 20, 2013) (online at missoulian.com/news/local/vote-that-killed-medicaid-bill-was-a-mistake-lawmaker-says/article_28deaa2e-a92e-11e2-903e-001a4bcf887a.html), *Missouri Lawmakers Torpedo Medicaid Expansion*, Politico (May 8, 2013) (online at www.politico.com/story/2013/05/missouri-lawmakers-torpedo-medicaid-expansion-91040.html)).

[9] Kaiser Family Foundation, *Analyzing the Impact of State Medicaid Expansion Decisions* (July 2013) (online at kaiserfamilyfoundation.files.wordpress.com/2013/07/8458-analyzing-the-impact-of-state-medicaid-expansion-decisions2.pdf).

[10] Governor Rick Perry, quoted in *GOP Governors Play Politics with Life and Death,* U.S. News and World Report (June 4, 2013) (online at www.usnews.com/opinion/blogs/pat-garofalo/2013/06/04/study-rejecting-obamacare-medicaid-expansion-costs-gop-governors-money).

[11] *States that opt out of Medicaid expansion stand to lose billions*, BMJ (June 4, 2013) (online at www.bmj.com/content/346/bmj.f3651.full).

The states that reject the Medicaid expansion will turn down an opportunity to improve economic growth and increase revenues. An expansion of Medicaid will create more jobs as the health needs of low-income families are met, leading to a stronger economy and more revenue for state governments, and the coverage provided by Medicaid will save money in other state safety net health care programs. In fact, the state of Ohio could see budget savings of $1.8 billion over the next decade by participating in the Medicaid expansion, and Florida's participation could increase revenues by $100 million annually – the exact opposite of what Republican governors have predicted.[12]

C. Refusal to Establish State-Based Health Insurance Marketplaces

Republican leaders have often stated that they oppose the Affordable Care Act because it does not allow for sufficient state flexibility. For example, Governor Bob McDonnell of Virginia, a Republican, has criticized the law as "a one-size-fits-all cumbersome mandate from D.C."[13] But when given a key opportunity to tailor the application of the Affordable Care Act to meet the needs of their own states, 26 Republican governors or state legislatures have refused to do so.[14]

The Affordable Care Act is implemented primarily through health insurance exchanges – open, transparent marketplaces where consumers can purchase insurance coverage. The law gives states the authority to set up their own marketplaces, which allows states to maintain autonomy over their health insurance industries while designing the marketplace so that it can meet individual state needs. The law also provides generous funding to cover state costs.[15] If states decide not to establish marketplaces, the law directs the federal government to establish a marketplace to be used by residents of those states.

---

[12] Center for American Progress, *10 Frequently Asked Questions About Medicaid Expansion* (Apr. 2, 2013) (online at www.americanprogress.org/issues/healthcare/news/2013/04/02/58922/10-frequently-asked-questions-about-medicaid-expansion/).

[13] *Bobby Jindal, Bob McDonnell Slam Obamacare as a Job Killer*, Daily Caller (June 29, 2013) (online at dailycaller.com/2012/06/29/bobby-jindal-bob-mcdonnell-slam-obamacare-as-a-job-killer/).

[14] Of the 27 states that have not implemented state-based exchanges, 25 have Republican governors. In Missouri, Democratic Governor Jay Nixon supported an exchange but was unable to implement it because of a state ballot initiative. (*Federal Government Will Start Setting Up Missouri's Health Exchange*, St. Louis Today (Nov. 12, 2012) (online at www.stltoday.com/news/local/govt-and-politics/political-fix/federal-government-will-start-setting-up-missouri-s-health-exchange/article_4bee6ae8-6b8d-5c6c-9ecf-e90dd36234b6.html). In Montana, Democratic Governor Steve Bullock supported a state-based exchange, but was blocked in the Republican-controlled legislature.

[15] Center on Budget and Policy Priorities, *Status of State Health Insurance Exchange Implementation* (June 14, 2013) (online at www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf).

One of the few Republican governors to implement a state-based marketplace, Idaho's Gov. Butch Otter, described the benefits of states running their own marketplaces, noting that turning down the opportunity to run a state marketplace and instead requiring a federal marketplace:

> would invite increased federal involvement in our state affairs through regulation of our insurance markets, forfeiting the creation of jobs in Idaho to other states, adding to the enlargement of the federal bureaucracy and incurring federal fees for operating costs associated with running a federal exchange. ... [T]here are numerous documented areas that the state will have the ability to make decisions in creating and administering the state-run exchange. In addition to those, a state-based exchange will provide Idaho with more control over operational costs, controlling costs to consumers. It will rely on existing state agencies to perform functions they already perform instead of creating duplicate federal functions.[16]

Despite these benefits, 26 states have refused to implement state-based health insurance marketplaces. This reduces flexibility for residents of their states and places added strain on the Department of Health and Human Services (HHS), complicating implementation of the law. HHS Secretary Kathleen Sebelius said: "Implementation had been hampered [by] red-state governors and legislators who have rejected state-run insurance exchanges. ... It is very difficult when people live in a state where there is a daily declaration, 'We will not participate in the law,' for them to figure out whether they are going to benefit."[17]

D. Undermining Enrollment in Health Insurance Marketplaces

Two leading Republican groups, FreedomWorks and Americans for Prosperity, announced earlier this month that they would begin a multimillion-dollar campaign to "dissuade uninsured Americans from obtaining health coverage."[18]

One press report described the goal of this campaign:

> FreedomWorks and Americans for Prosperity, a conservative issue group financed by billionaire brothers David and Charles Koch, known for funding conservative causes, are planning separate media and grassroots campaigns aimed at adults in their 20s and 30s - the very people Obama needs to have sign up for healthcare coverage in new online insurance exchanges if his reforms are to succeed. "We're trying to make it socially acceptable to skip the exchange," said

---

[16]Office of Gov. Butch Otter, Health Insurance Exchange Myth, Fact (Jan. 18, 2013) (online at www.cdapress.com/news/local_news/article_d4bea2c6-619f-11e2-9e5b-001a4bcf887a.html).

[17]*Sebelius: Obamacare Rollout Tougher than White House Expected*, The Hill (Apr. 9, 2013) (online at thehill.com/blogs/blog-briefing-room/news/292531-sebelius-obamacare-rollout-more-complicated-than-anticipated).

[18]*Republicans Prepare for 'Obamacare' Showdown, With Eye to 2014 Elections*, Reuters (July 25, 2013) (online at www.reuters.com/article/2013/07/25/us-usa-healthcare-republicans-idUSBRE96O0EJ20130725).

> Dean Clancy, vice president for public policy at FreedomWorks, which boasts 6 million supporters. The group is designing a symbolic "Obamacare card" that college students can burn during campus protests.[19]

The goal of these efforts is not to modify the law or improve it, but to ensure the failure of the Affordable Care Act, even at the expense of placing individuals who would otherwise need and choose to purchase health insurance at risk.

One analyst described the effort as designed to "ruin the system for people who *want* the help Obamacare offers them. ... [T]he campaign effectively amounts to asking people to continue putting their well-being and livelihoods at risk for the good of the cause of keeping health care for sick people unaffordable."[20]

E. Denying Funding Requests to Implement the Affordable Care Act

Republicans in Congress have repeatedly denied routine HHS budget requests for administrative funding needed to implement the Affordable Care Act, denying funding requested in FY 2012 and FY 2013 and subjecting HHS to the cuts in the sequester. This has left the agency with a shortfall of billions of dollars in administrative funding. This "shoestring budget" has hampered HHS's ability to implement the law.[21]

According to the *Washington Post*:

> HHS has repeatedly requested additional funds from Congress to assist in the implementing but has been turned down. After Congress rejected a request in March for nearly $1 billion in additional spending for fiscal 2013, the White House asked for $1.5 billion for fiscal 2015 to set up and run dozens of exchanges that will provide Americans options for health insurance.[22]

F. Attacking Affordable Care Act Education Efforts

On multiple occasions, Republicans in Congress have acted to undermine efforts to inform the public about the Affordable Care Act.

---

[19] *Republicans Prepare for 'Obamacare' Showdown, With Eye to 2014 Elections*, Reuters (July 25, 2013) (online at www.reuters.com/article/2013/07/25/us-usa-healthcare-republicans-idUSBRE96O0EJ20130725).

[20] *Undeniable Sabotage,* Talking Points Memo (July 25, 2013) (online at talkingpointsmemo.com/archives/2013/07/undeniable_sabotage.php).

[21] *Budget Request Denied, Sebelius Turns to Health Executives to Finance Obamacare*, Washington Post (May 10, 2013) (online at www.washingtonpost.com/blogs/wonkblog/wp/2013/05/10/budget-request-denied-sebelius-turns-to-health-executives-to-finance-obamacare/).

[22] *Budget Request Denied, Sebelius Turns to Health Executives to Finance Obamacare*, Washington Post (May 10, 2013) (online at www.washingtonpost.com/blogs/wonkblog/wp/2013/05/10/budget-request-denied-sebelius-turns-to-health-executives-to-finance-obamacare/).

In September 2012, for example, Republicans on the Energy and Commerce Committee opened an investigation of HHS grants to states after the State of California signed a contract with Ogilvy Public Relations that included discussion of placing mentions of the Affordable Care Act in popular television shows.[23] Republican leaders on the Energy and Commerce Committee described California's plan to inform the public about new insurance requirements via popular media as an effort "to subsidize Hollywood and insert propaganda into the popular culture."[24] House Republican Conference Chair Jeb Hensarling criticized the efforts of HHS to inform the public about the new Affordable Care Act benefits and requirements as "wasting taxpayer dollars on PR campaigns."[25]

The contrast between these actions and the actions of Republicans when the Bush Administration was implementing Medicare Part D is stark. Beginning in 2003, the Bush Administration spent more than $70 million on a public relations campaign, including an expenditure of $600,000 to fly a blimp over football stadiums, state fairs, and an auto race to promote its 1-800-MEDICARE information line.[26] After the Medicare Part D drug benefit was passed into law, the Bush Administration spent even more, planning a three-year, $300 million public relations effort that included a $25 million advertising campaign and a bus tour featuring high-level Administration officials that visited 100 cities in 2005.[27] Republican leaders were supportive of this spending.

G. Intimidating Potential Participants in Public Education Efforts

In May 2013, the *Washington Post* reported that HHS Secretary Sebelius had requested assistance from private sector entities to help fund efforts to educate the public about the Affordable Care Act. This prompted Republican leaders to open an investigation of HHS and Enroll American, a nonprofit organization conducting a public education campaign.[28] Over 20

---

[23]Letter from Energy and Commerce Committee Chairman Fred Upton and Senate Finance Committee Ranking Member Chuck Grassley to Kathleen Sebelius, Secretary, Department of Health and Human Services (Sept. 28, 2012); Letter from Chairman Fred Upton and Oversight and Investigations Subcommittee Chairman Cliff Stearns to Robert Mathis, Managing Director, Ogilvy Public Relations (Sept. 27, 2012).

[24] Letter from Chairman Fred Upton and Chairman Cliff Stearns to Robert Mathis, Managing Director, Ogilvy Public Relations (Sept. 27, 2012).

[25] House Republican Conference Chair Jeb Hensarling, Medicare on Main Street (Oct. 5, 2012).

[26]*Look Up in the Sky - it's the Medicare Blimp*, St. Petersburg Times (Oct. 23, 2003).

[27]See, Government Accountability Office, Media Contracts: Activities and Financial Obligations for Seven Federal Departments (Jan. 13, 2006) (GAO-06-305); *Medicare Drug Benefit Outlined in Campaign*, The Washington Post (Oct. 10, 2005); *Health Secretary Urges Local Leaders to Tout Drug Plan*, The Denver Post (Aug. 28, 2005).

[28]Energy and Commerce Committee, *Committee Launches Probe Following Reports of HHS Soliciting Donations from Companies it Regulates* (May 13, 2013) (online at energycommerce.house.gov/press-release/committee-launches-probe-following-reports-hhs-soliciting-donations-companies-it).

different companies were sent document requests related to whether they had been asked for assistance from Secretary Sebelius.[29]

This appears to have had the desired effect. The *New York Times* reported that it caused "such a strong partisan uproar that potential donors bec[ame] skittish about contributing" to the group's education efforts.[30]

Republicans also engaged in other intimidation tactics directed against organizations considering working with HHS to educate the public about the Affordable Care Act. When news reports indicated that the National Football League (NFL) and National Basketball Association (NBA) were considering working with HHS to inform the public about the law's new benefits, Republican leaders sent letters to the leagues urging them not to do so, urging "caution ... against being coerced into doing their dirty work for them,"[31] and warning that "it is difficult to understand why an organization like yours would risk damaging its inclusive and apolitical brand by lending its name to its promotion."[32] Soon after receiving these letters, the NFL announced they would not be participating in any efforts with HHS to inform the public about the Affordable Care Act.

H. Demands to Defund the Affordable Care Act or Shut Down the Government

Republicans and Democrats are currently negotiating over a continuing resolution to prevent a government shutdown in 2013. However, key Republicans in both the House and Senate – including national party leaders like Sen. Rand Paul, Sen. Marco Rubio, and Rep. Michelle Bachmann – have demanded ending funding for the Affordable Care Act as a prerequisite to passage of any legislation. Republican House leaders wrote that a continuing resolution should "defund the implementation and enforcement of the Patient Protection and

---

[29]Energy and Commerce Committee, *Committee Launches Probe Following Reports of HHS Soliciting Donations from Companies it Regulates* (May 13, 2013) (online at energycommerce.house.gov/press-release/committee-launches-probe-following-reports-hhs-soliciting-donations-companies-it).

[30]*Potential Donors to Enroll America Grow Skittish*, New York Times (May 19, 2013) (online at www.nytimes.com/2013/05/20/us/politics/potential-donors-to-enroll-america-grow-skittish.html?pagewanted=all&_r=0).

[31]Letter from Rep. Steve Scalise to NFL Commissioner Roger Goodell and NBA Commissioner David Stern (June 27, 2013) (online at scalise.house.gov/sites/scalise.house.gov/files/documents/Letter%20to%20NFL%20and%20NBA.pdf).

[32]Letter from Sen. Mitch McConnell and Sen. John Cornyn to Roger Goodell (June 27, 2013).

Affordable Care Act;"[33] Senate leaders wrote, "we will not support any continuing resolution or appropriations legislation that funds further implementation or enforcement of ObamaCare."[34]

Other Republicans have been critical of these efforts. Sen. Tom Coburn stated flatly that this idea "will not work" and Sen. Richard Burr called the idea to defund the law "the dumbest idea I've ever heard."[35]

I. Threats to Deny Constituent Service Requests

Constituent service requests – helping citizens who ask their members of Congress for assistance navigating federal programs like Medicare, Social Security, and those provided by the Department of Veterans Affairs – is a basic part of congressional service. Members of Congress routinely have staff in Washington and in their districts to help constituents with these requests.

Democratic members of Congress – even those who voted against the law – held town halls, participated in enrollment events, and routinely provided assistance to residents of their districts who sought help determining if they qualified for benefits under Medicare Part D and enrolling in the program. Some Republicans appear to be taking this approach with the Affordable Care Act. For example, Rep. Phil Gingrey, has said, "If a constituent wants to know something, I'm going to be truthful to then, even if I absolutely hate the program."[36]

But it appears that other Republican members are taking a different – and unprecedented – approach, indicating they will not help constituents with questions about the Affordable Care Act. A recent article in *The Hill* asked numerous Republican House members about their approach to constituent services for health reform. *The Hill* reported:

> Some Republicans indicated [that] they will not assist constituents in navigating the law and obtaining benefits. Others said they would tell people to call the Department of Health and Human Services (HHS). "Given that we come from Kansas, it's much easier to say, 'Call your former governor,'" said Rep. Tim Huelskamp (R), referring to HHS Secretary Kathleen Sebelius. "You say, 'She's the one. She's responsible. She was your governor, elected twice, and now you

---

[33] *Republicans Pen Obamacare Letter to John Boehner*, Politico (July 25, 2013) (online at www.politico.com/story/2013/07/obamacare-funding-spending-bills-94757.html#ixzz2aTLAgRAE).

[34] Letter to Senator Harry Reid from Sens. Mike Lee, Marco Rubio, Ted Cruz, James Risch, Rand Paul, James Inhofe, David Vitter, John Thune, Jeff Chiesa, Mike Enzi, Deb Fischer, and Chuck Grassley (July 25, 2013) (online at www.lee.senate.gov/public/index.cfm/press-releases?ID=93817977-d333-4992-8e2d-182ce24d2153).

[35] *Coburn: Plan to Defund Obamacare Could Destroy GOP,* Washington Post (July 26, 2013) (online at http://www.washingtonpost.com/blogs/post-politics/wp/2013/07/26/coburn-plan-to-defund-obamacare-could-destroy-gop/).

[36] *GOP to Constituents: Questions on Obamacare? Call Obama*, The Hill (June 15, 2013) (online at thehill.com/blogs/healthwatch/health-reform-implementation/305777-gop-to-constituents-questions-on-obamacare-call-obama#ixzz2aTPhzrEe).

reelected the president, but he picked her.'" Huelskamp said. "We know how to forward a phone call," said Rep. Jason Chaffetz (R-Utah). "I have two dedicated staff who deal with nothing, but ObamaCare and immigration problems," he added. "I'm sure there will be an uptick in that, but all we can do is pass them back to the Obama administration. The ball's in their court. They're responsible for it."[37]

J. Misinforming Citizens about the Impact of Health Care Reform on Insurance Premiums

Republican leaders have repeatedly claimed that the Affordable Care Act will cause a catastrophic increase in insurance premiums since Congress first began considering these reforms.[38] As the date on which individuals can purchase health insurance on the marketplace gets closer, actual information on premiums is now available. This data shows that premiums will be even lower than predicted. For example, an HHS analysis released earlier this month found that in the states for which data are available, the lowest cost silver plan in the individual market in 2014 will cost, on average, 18% less than the rate predicted by the Congressional Budget Office; on the small group market, the average premium that small employers will pay is 18% lower than the same plan would cost absent the Affordable Care Act.[39]

But in several Republican-controlled states, insurance commissioners have released information in a misleading fashion, implying that rates will be higher than expected. This creates bad publicity for the Affordable Care Act and potentially convinces residents that they will not be able to afford coverage. For example, on July 19, 2013, Indiana's Chief Deputy Insurance Commissioner under Republican Governor Mike Pence released information claiming that insurance rates for individuals in the state would increase by 72%, with plan costs increasing to $570 monthly.[40] He claimed, "This new data regrettably confirms the negative impact of the

---

[37] *GOP to Constituents: Questions on Obamacare? Call Obama*, The Hill (June 15, 2013) (online at thehill.com/blogs/healthwatch/health-reform-implementation/305777-gop-to-constituents-questions-on-obamacare-call-obama#ixzz2aTPhzrEe).

[38] See, *Weekly Remarks: John Boehner Says Health Costs Will Soar; Obama Sees Economy Rebounding*, Los Angeles Times (Oct. 31, 2009) (online at latimesblogs.latimes.com/washington/2009/10/john-boehner-healthcare-barack-obama-economy.html).

[39] L. Skopec and R. Kronsick, *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Nearly 20% Lower than Expected,* U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (July 2013) (online at aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.cfm).

[40] *State Says Obamacare Will Force 72% Increases in Individual Insurance Plan Rates,* Indianapolis Star (July 19, 2013) (online at www.indystar.com/article/20130718/BUSINESS/307180100/State-says-Obamacare-will-force-72-percent-increase-individual-insurance-plan-rates).

Affordable Care Act on the insurance market in Indiana. ... These rates call into question just how affordable health insurance will really be for many Hoosiers."[41]

The State released no other information at the time. But independent analysts were able to obtain additional information on premiums and revealed that state officials had used a misleading average to get the $570 cost estimate. They found that the "figure that Indiana put out ... doesn't, in fact, tell us much at all. It's pretty much just a great number to make the cost of health insurance sound expensive in Indiana and a horrible one to use in thinking about how much Hoosiers will pay for coverage come January."[42] In fact, sample filings from insurers in Indiana reveal that premiums will be as low as $125 a month for a 20-year-old and $307 a month for a 47-year-old, before tax credits and subsidies, which will reduce out-of-pocket costs even more for many individuals.[43]

Indiana is not the only state to put out misleading figures on insurance premiums. In June 2013, Ohio's Republican Lt. Governor Mary Taylor released information claiming that "initial analysis of the proposed rates show consumers will have fewer choices and pay much higher premiums for their health insurance starting in 2014."[44] But a more detailed analysis of these claims found numerous problems: misleading use of averages, cherry picking plans to imply that rates currently paid by Ohio residents were lower than they are, comparing the cost of plans that now offer limited benefits but will offer full benefits in 2014, and failing to take into account the impact of tax credits and subsidies to reduce premium costs.[45]

Republicans on the Energy and Commerce Committee have also exaggerated the impact of the Affordable Care Act on insurance rates, releasing an analysis in May 2013 claiming that "consumers purchasing health insurance on the individual market may face premium increases of

---

[41] *State Says Obamacare Will Force 72% Increases in Individual Insurance Plan Rates,* Indianapolis Star (July 19, 2013) (online at www.indystar.com/article/20130718/BUSINESS/307180100/State-says-Obamacare-will-force-72-percent-increase-individual-insurance-plan-rates).

[42] *Indiana Says Health Plan Costs Will Spike to $570. That's Not the Full Story,* Washington Post (July 20, 2013) (online at www.washingtonpost.com/blogs/wonkblog/wp/2013/07/20/indiana-says-health-plan-costs-will-spike-to-570-thats-not-the-full-story/).

[43] *Hoosier Hustle? Another Dubious Attack on Obamacare*, The New Republic (July 21, 2013) (online at www.newrepublic.com/article/113973/obamacare-rate-shock-indiana-what-gop-officials-didnt-say#).

[44] *You Call This Insurance? Ohio's Lieutenant Governor is Misleading the Public About Obamacare Rate Shock*, The New Republic (June 11, 2013) (online at www.newrepublic.com/article/113440/obamacare-rate-shock-higher-prices-can-mean-better-benefits).

[45] *You Call This Insurance? Ohio's Lieutenant Governor is Misleading the Public About Obamacare Rate Shock*, The New Republic (June 11, 2013) (online at www.newrepublic.com/article/113440/obamacare-rate-shock-higher-prices-can-mean-better-benefits).

nearly 100 percent on average, with potential highs eclipsing 400 percent.[46] But this analysis was also flawed, selectively using rate information provided by insurers, failing to incorporate key cost saving provisions, and overlooking of the benefits of improved coverage.[47] Subsequent analyses have found that the rate shock predicted by Republicans has not materialized. [48]

III. CONCLUSION

Commentators have written that Republican members of Congress, Republican governors, and other top Republican officials and supporters are actively working to sabotage the Affordable Care Act. This staff report analyzes ten of the strategies they are using in the campaign to undermine the law. These efforts may provide a short-term political gain for the Republican Party, but they come at a heavy price. The Republicans' actions are denying health coverage for millions of the poorest residents living in Republican-controlled states. They are raising costs for hospitals, health providers, and taxpayers in Republican states. And they are working to dissuade individuals who need health coverage from signing up for coverage.

---

[46] House Committee on Energy and Commerce, Republican Staff, *Obamacare Oversight: the Looming Premium Rate Shock*, 113th Cong. (May 13, 2013).

[47] Memorandum from Committee on Energy and Commerce, Democratic Staff, Investigation *on the Impact on Cost of Coverage of the Affordable Care Act*, 113th Cong. (May 13, 2013).

[48] L. Skopec and R. Kronsick, *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Nearly 20% Lower than Expected,* U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation (July 2013) (online at aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.cfm).

Mr. WAXMAN. It describes 10 ways that Republican leaders in Congress and statehouses have worked to sabotage the law. As this memorandum documents, independent, nonpartisan observers have been harsh in their depiction of what Republicans are doing. USA Today says, Republicans are using, quote, "the most cynical of tactics," and inflicting, quote, "human misery," end quote, on their constituents. Ezra Klein writes that Republicans are trying to, quote, "knowingly damage America's healthcare system on the off chance the damage is severe enough to help them accomplish a much larger policy goal," end quote.

Tomorrow, the House will vote to repeal the law for the 40th time. Many Republicans are threatening to shut down the government in order to force repeal of this law. Republicans in Congress are intimidating groups working to inform the public about the law. Their allies outside of Congress are actively working to discourage their uninsured constituents from enrolling in coverage. Some Republican Members even appear to be saying they will not perform basic constituent services to help citizens who live in their districts sign up for the benefits of the Affordable Care Act.

Noted congressional scholar Norm Ornstein has described these actions as, quote, "sharply beneath any reasonable standards of elected officials with the fiduciary responsibility of governing," end quote. He called them, quote, "simply unacceptable, even contemptible."

The Affordable Care Act is the law of the land. And because of this law, tens of millions of Americans will soon be able to receive affordable, high quality healthcare coverage for the first time. As Administrator Tavenner will tell us today, she and others at HHS are doing yeomen's work to make sure the law works. All of our constituents, Republicans and Democrats, will enjoy these benefits. I thank her and her Department for their work, and I look forward to her testimony. Thank you, Madam Chair.

Ms. BLACKBURN. Gentleman yields back.

At this time, I recognize the subcommittee chairman, Mr. Pitts, for 5 minutes.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Madam Chairman.

Administrator Tavenner, thank you for appearing before us today.

For months, various administration officials, including HHS Secretary Sebelius, have been telling Congress that implementation of the President's healthcare law is on track and that statutory deadlines will be met. And yet earlier this year we were informed that the Federal preexisting conditions program had suspended enrollment and cut payments to providers for existing patients. In April of this year, HHS announced it was delaying full implementation of the Small Business Health Options Program, or SHOP exchanges, which were designed to offer small businesses multiple health insurance plans from which to choose. On July 2nd, the administration announced via Treasury Department blog post that the employer mandate would be delayed for 1 year, until January

1, 2015. Just a few days later, HHS announced that it had decided to disregard the requirement that State exchanges verify individuals' income when applying for exchange subsidies.

Based on a recent HHS decision to implement what they simply want, rather than what is statutorily required, what assurances do we have that exchanges will be ready to enroll individuals in just 60 days and that States are ready as well? How can we believe that provisions deemed inconvenient by the administration, such as verifying that someone is actually eligible for a taxpayer-funded subsidy, won't be labeled as too complex to administer and simply be ignored? My constituents want to know what to expect over the next couple of months and what assurances that only those individuals who are eligible for subsidies will be receiving them. American taxpayer dollars should be protected and not hastily spent on a law that may not be ready for primetime or on policies that don't require the utmost operational integrity.

Our constituents have concerns, and they need answers. And with just 60 days until the large pieces of this law get started, I trust you came prepared to answer these concerns.

Thank you, Madam Chair. I yield balance of my time to Dr. Murphy.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Thank you, Mr. Chairman.

Administrator Tavenner, thank you for appearing before us today.

For months, various administration officials, including HHS Secretary Sebelius, have been telling Congress that implementation of the President's health care law is on track and that statutory deadlines will be met.

And, yet, in April of this year, HHS announced it was delaying full implementation of the Small Business Health Options Program or SHOP Exchanges, which were designed to offer small businesses multiple health insurance plans from which to choose.

On July 2, the administration announced via a Treasury Department blog post, that the employer mandate would be delayed for one year, until January 1, 2015.

Just a few days later, HHS announced that it had decided to disregard the requirement that State exchanges verify individuals' income when applying for Exchange subsidies.

Based on recent HHS decisions to implement what they simply "want" rather than what is statutorily required, what assurances do we have that Exchanges will be ready to enroll individuals in just 60 days and that states are ready as well?

How can we believe that provisions deemed "inconvenient" by the administration-such as verifying that someone is actually eligible for a taxpayer-funded subsidy—won't be labeled as too complex to administer and simply be ignored?

My constituents want to know what to expect over the next couple of months and want assurances that only those individuals who are eligible for subsidies will be receiving them.

American taxpayer dollars should be protected and not hastily spent on a law that may not be ready for primetime or on policies that don't require the utmost operational integrity

Our constituents have concerns and they need answers and with just 60 days until the large pieces of this law get started, I trust you came prepared to answer their concerns.

Thank you, Mr. Chairman, and I yield back.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. I thank the gentleman.

Since the Affordable Care Act was enacted in March of 2010, this committee has heard from numerous officials from the administration telling us that all is well. But because this committee has worked tirelessly to monitor implementation, we know that the administration has been promising one thing and delivering another. The CLASS Act had to be shut down because it was totally unsustainable. In April, more than 1,400 groups providing insurance to 3.1 million were given waivers from the law's mandates in 2011. Employers have been complaining for months about the costs increasing and how they had to drastically cut employees.

Last month, every employer was given a waiver hidden in a 4th of July week blog. But the American people get no waiver. We are promised rigorous oversight, but last month the IRS and HHS, buried in an announcement, said they were going to scrap income coverage and verification for the exchanges. The President promised premiums would go down, but millions of families are seeing rates going up. The Teamsters and electric workers are saying they oppose the bill because of the problems it is going to cause.

When the administration announced it would delay the employer mandate, not a single word was spoken about what is wrong with the law; instead they continue to blame those of us who are doing what we are supposed to be doing, shining a light of transparency. There is a lack of trust because the bill was written behind closed doors, the Senate bill was different from the one that passed this committee, our markup version disappeared, they have hidden or buried changes in rules or blogs, they have ignored our concerns, denied prices were going up, and the administration focus has been to hire millions of people to help them sell it.

Tens of thousands of employees, employers, doctors, and millions of Americans who oppose or have grave concerns about this bill can't all be wrong. It is no surprise the public doesn't trust the administration to properly implement this law. If you are not going to trust the American people and tell them the truth, the American people won't trust those of us who are looking at implementing this law in a straightforward way.

I now yield to Mr. Barton. Thank you.

OPENING STATEMENT OF HON. JOE BARTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BARTON. Thank you, Dr. Murphy.

I live in Ennis, Texas. It is a town of about 15,000 people just south of Dallas. This is the headline in the Ennis Daily News, Wednesday, July the 17th, 2013: "Insurance squeezing the budget. Total premium costs to jump nearly $50,000 monthly for city plan. City employees will see their health insurance premium costs more than double in response to changes in the market brought about through the Affordable Care Act." And then it goes on to outline what those costs are. Later in the article it says that because of these costs many of these city employees are probably going to opt out of the city insurance plan and take their chances in the health exchange, if that ever gets up and running.

Madam Chairwoman, that says it better than anything I could say. I will submit this article for the record when we get to that point.

Ms. BLACKBURN. Without objection, so ordered.
[The information follows:]

The Ennis Daily News

Wednesday, July 17, 2013 www.ennisdailynews.com 75¢

Insurance squeezing budget

Total premium costs to jump by nearly $50,000 monthly for city plan

Nick Todaro
nick@ennisdailynews.com

City employees will see their health insurance premium costs more than double in response to changes in the market brought about through the Affordable Care Act.

City Manager Steve Howerton outlined specific changes to the city's coverage offerings for city commissioners Tuesday that include hikes across the board to cover nearly $50,000 in increased monthly costs contained in the latest boost of premium rates. It is by far the largest budgetary impact the city faces this year, he said.

The city's costs per employee will increase faster than employees' contributions to their coverage, but employees also face triple the deductible level of last year's plan under the most supported option open to the city's decision-makers.

Given that option sees premium costs increasing by 23.6 percent. Ennis was originally given a premium increase of 43.2 percent by its insurance carrier to provide the same benefits in the 2013-2014 budget cycle that it has provided in 2012-2013.

"What we've had to do is really reduce our benefits to our employees," Howerton said.

For individuals, deductibles have been $500 for an individual and $1,000 for a family. Under the proposed plan, those levels increase to $1,500 for an individual and $3,000 for a family.

See INSURANCE, page 8

Weather

Tonight:
Storm chance lingers
Low 73

Thursday:
Slight chance of storms
High 95

Death

SANTOS, Ernestine
See page 3

Around Town

Cook-off set

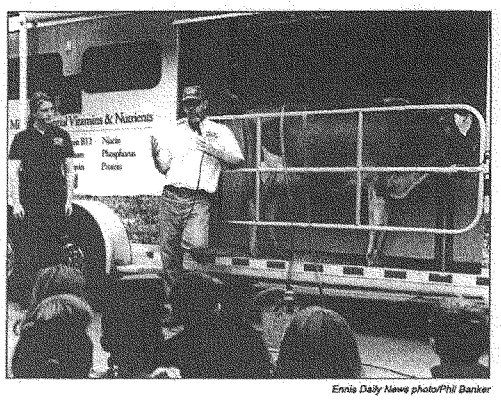
The Ennis Police Officers Association is planning their first-ever barbecue cook-off on July 19-20 at the Sokol Hall parking lot.

The entry fee for each team is $75 and one smoked brisket, or $75 and a $20 donation. Membership in the Lone Star Barbecue Society is not required to enter.

Proceeds of the event will help fund the annual Santa Cops toy drive. Last Christmas the drive gave toys, clothing and other needed items to approximately 500 needy children in Ennis and surrounding areas. The Sokol bar will be open during the cookoff, and barbecue sandwiches will be on sale. Check-in begins at 4 p.m. Friday, July 19. Teams must be set up prior to the cooks' meeting at 9 a.m. Saturday, July 20. For more information, contact Brian Clark at 972-816-3205.

Golden Circle gets moving

The Golden Circle Senior Activity Center hosts a "Step Up to Scale Down and Lower Blood Pressure" program from 9 to 10:30 a.m. Mondays. For more information about the free offering, call Marie Dyess, Master Wellness Volunteer at the Texas Agrilife Extension, at 214-789-2886.



Ennis Daily News photo/Phil Banker

Dairy farmers visit EPL readers

Kayler Campbell and Aaron Sanders with Southwest Dairy Farmers brought Diamond the cow and their mobile classroom to the Ennis Public Library on Tuesday. Students with the library's Summer Reading Program learned how cows are milked, as well as the health benefits and products made from milk.

Three booked in fight

Phil Banker
phil@ennisdailynews.com

Ennis police arrested three men in connection with an early Monday morning brawl.

Lt. Mike Hopson of the Ennis Police Department said Officer Roger Cole and Cpl. Sherman Swafford responded to a reported fight shortly after midnight Monday at the EZ Mart located at 1015 S. Kaufman St.


Valdez


Majors


Cervantes

By the time the officers arrived, the suspects reportedly fled the scene in a brown minivan. While Officer Jason McCurdy remained at the store with the victim, Cole and Swafford pursued the van.

Hopson said the officers stopped the van in the 100 block of West Main Street, questioning the driver and passengers. Hopson said the driver of the van, 20-year-old Jordan Valdez of Italy, was "uncooperative."

Police arrested Valdez pending charges of disorderly conduct and driving without a license. They jailed 23-year-old Vandrakes Majors of Bardwell and 18-year-old Nicholas Cervantes of Ennis pending charges of assault.

Club aims for healthy, happy kids

Phil Banker
phil@ennisdailynews.com

The Boys and Girls Club of Ennis is teaming up with the Texas A&M Agrilife Extension to help teach kids about the importance of staying fit, healthy and happy.

Extension agents will host Happy, Healthy Kids Day from 12:30 to 3 p.m. Monday at the club, located at 1211 S. Clay St.

The event's presentations will touch upon subjects including nutrition, increasing physical activity, water and fire safety, bullying prevention and flu prevention.

Extension agent Rita Hodges said deputies with the Ellis County Sheriff's Office as well as Master Wellness volunteers and Forest Service personnel stepped up to give of their time and expertise to help kids.

"The more skills we can teach them, the better," Hodges said.

She said this is the first time this particular presentation has ever come to Ennis. She said a previous trial run of the program at Avalon ISD worked so well, she wanted to bring it to even more kids.

"It was so successful that we suggested it to (the Boys and Girls Club) and they were very excited," Hodges said. "Our committee thought it would be a good idea to reach as many kids as possible with information on healthy lifestyles."

To go

Happy, Healthy Kids Day is set from 12:30 to 3 p.m. Monday at the Boys and Girls Club of Ennis, located at 1211 S. Clay St.


Hodges

Hodges said in addition to presentations, her staff will be preparing "goodie bags" for kids to take home, complete with healthy recipes and information on how to maintain healthy lifestyles at home.

"They can only do so much if this isn't talked about at home," she said.

Carey Bryan, executive director of the Boys and Girls Club of Ennis, said the event is part of their longstanding working relationship with the extension office.

"It's something we're excited about," Bryan said. "We're looking forward to working with the university."

Ennis Daily News photo/Phil Banker

Slavik named Rotarian of Year

Sally Slavik, Ennis Rotary Club secretary, was named Rotarian of the Year on Tuesday night by outgoing Rotary Club President Steve Huff.

Ennis Daily News photo/Nick Todaro

City recognizes former official

Mayor Russell Thomas presents former Mayor Pro Tem Bob Taylor with a service plaque for 18 years of service as an elected official on the Ennis City Commission on Monday night. Taylor called it his honor to serve the city and its citizens.

Gunfire leads to arrest

Phil Banker
phil@ennisdailynews.com

Arrez

An Ennis man is in jail after he allegedly fired a gun repeatedly in the back yard of a home on Swallow Drive.

Ennis Police Department spokesman Mike Hopson said officers arrested 26-year-old Valente Arrez on July 13 after responding to a disturbance call in the 1500 block of Swallow Drive. Hopson said witnesses told officers upon their arrival that Arrez was "out of control," breaking things in the home and possibly posing a threat to himself and others.

At that time, Hopson said Officer Brian Clark heard approximately six gunshots from the back yard of the home. Officers went into the back yard and held Arrez at gunpoint until backup arrived.

Hopson said officers were not in danger at any time.

Arrez was arrested pending charges of deadly conduct and assault of a public servant. He remains in the Wayne McCollum Detention Center pending the posting of $32,500 in bond.

State executes deputy's killer

HUNTSVILLE (AP) — A Texas man convicted of fatally shooting a retired sheriff's deputy during the robbery of an amusement center more than a decade ago was put to death Tuesday.

John Manuel Quintanilla received lethal injection for gunning down 60-year-old Victor Billings at a game room in Victoria, about 125 miles southwest of Houston. The 2002 slaying came just a few months after Quintanilla had been released from prison after serving a sentence for several burglary convictions.

Asked to make a final statement before his execution, Quintanilla told his wife he loved her.

"Thank you for all the years of happiness," he said.

He never acknowledged his victim's friends or relatives, including two daughters, who watched through a window.

As the lethal drug began taking effect, he snored about a half dozen times, then stopped breathing. At 7:32 p.m. CDT — 15 minutes after being given the drug — he was pronounced dead.

Quintanilla's wife, a German national who married him by proxy while he was in prison, watched through an adjacent window and sobbed.

Quintanilla, 36, became the ninth Texas inmate to receive lethal injection this year and the 501st since the state resumed carrying out capital punishment in 1982. His was the first of two executions set for this week; the other is planned for Thursday.

Quintanilla's punishment was carried out after the U.S. Supreme Court refused two last-day appeals.

His lawyers contended his confession was coerced by authorities threatening to also charge one of his sisters and that the statement improperly was allowed into evidence at his trial in 2004. The lawyers obtained affidavits from two jurors who said the confession was a key to their decision to convict him.

"It is clear that Quintanilla would not have been convicted of capital murder if his confession had not been admitted — a fact confirmed by two of his jurors," appeals lawyer David Dow told the high court.

The appeal also argued Quintanilla had deficient legal help during his trial and in earlier stages of his appeals, and that his case would give justices the opportunity to define filing rules in light of recent death penalty rulings from the court.

INSURANCE cont. from page 1

Jess Haupt, commissioner for Ward 3 and owner of Globe Products and Buna Bean Coffee, raised questions during the discussion about the possibility of employees opting out of insurance coverage through the city and opting to shoulder individual penalties for not carrying insurance.

His costs as a business owner and the costs his employees face have also jumped by similarly large amounts, he said.

"Probably at some point if it keeps going up and coverage is going to become less and less and less, and employees aren't going to want to pay it so they'll opt out," Haupt said.

He worries Ennis will face a problem with its employee pool for group coverage if costs increase too quickly, but Howerton said the city has few options in handling the issue.

Mayor Russell Thomas said those who pay their own insurance costs know the more than three times the city's offered employee rate of $315.50 for employee plus family coverage.

"I pay $1,100 now," Walker said.

Perspective is important for considering how good the benefit is for employees, Howerton said.

"You're basically doubling the premium of employees and cutting their benefits in half," he said. "And it's always a balancing act."

PUBLIC NOTICE
EISD SPECIAL EDUCATION DEPARTMENT WILL DESTROY SPECIAL EDUCATION RECORDS

The Ennis ISD Department of Special Education will destroy the remainder of the district's special education records currently on file for students with a cessation date from special education of 5 years or greater. After the destruction of records, the special education office will keep only the student's name and birth date on file. If you have need of any educational records kept by the special education office of Ennis ISD, you must call 972-872-7041, or come to the EISD Administration Building at 303 West Knox and request copies of these records before July 25th, 2013. After July 25th, 2013 the records will no longer be made available by EISD.

EISD DEPARTAMENTO DE EDUCACIÓN ESPECIAL VA A DESTRUIR LOS REGISTROS

El Departamento de Educación Especial de Ennis ISD va a destruir el resto de los

Mrs. BLACKBURN. At this time, I recognize Ms. DeGette from Colorado for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you, very much, Madam Chair.

The Affordable Care Act is now the law of the land, and it is already bringing benefits to millions of Americans. But today we are standing before one of the most important moments of the ACA, and that is implementation. We are just 2 months away from the open enrollment period for the exchanges. That is why I would urge my colleagues on both sides of the aisle to work on educating constituents on how to make this new law work for individuals, families, and businesses.

I remember when we passed the Medicare Part D bill, and the Democrats, frankly, didn't like it. We didn't like the fact that the Administrator couldn't negotiate prescription drug prices. But, despite that, we all went out to our districts and we worked with our constituents to let them know how they could enroll. Why? Because this would help our constituents and, in fact, now Medicare Part D has become very, very popular.

I met a lady last week when I was in Denver who is paying on the individual market. She is 58 years old, and she is paying $600 a month on the individual market for insurance because she has a preexisting condition. I told her, as of October you will be able to enroll in the exchange in Colorado, and you can probably save yourself a bundle of money. She had no idea that this option even existed. And I think it is our job as elected representatives of our constituents to go out there and tell people like this woman that they can have these benefits and get the insurance they need and save money.

Now, an important step in doing this is to make sure that we go home and talk to our constituents in this August recess about that. So, Administrator Tavenner, I am really looking forward to hearing what the administration is planning to do to make sure people know about this.

Madam Chair, earlier this month, Energy and Commerce Democratic staff released fact sheets on the benefits of the Affordable Care Act in every district in the country, and I would ask unanimous consent to put those fact sheets into the record of this hearing today.

Ms. BLACKBURN. Without objection, so ordered.

[The information follows:]

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of California

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Matsui's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 4,500 seniors** in the district received prescription drug discounts worth **$4.5 million**, an average discount of **$390 per person in 2011, $490 in 2012**, and **$580 thus far in 2013**.
- **92,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **160,000 individuals** in the district – including **35,000 children** and **67,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **184,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **32,800 consumers** in the district received approximately **$2.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$65 per family in 2011**.
- **Up to 44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **195,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **113,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **30,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 9th Congressional District of California

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. McNerney's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,700 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,200 seniors** in the district received prescription drug discounts worth **$7.1 million**, an average discount of **$510 per person in 2011, $570 in 2012**, and **$520 thus far in 2013**.
- **95,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **168,000 individuals** in the district – including **43,000 children** and **64,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **195,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **34,300 consumers** in the district received approximately **$2.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$65 per family in 2011**.
- **Up to 49,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **207,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **114,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **32,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 18th Congressional District of California

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Eshoo's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,000 seniors** in the district received prescription drug discounts worth **$9.6 million**, an average discount of **$610 per person in 2011, $660 in 2012**, and **$920 thus far in 2013**.
- **97,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **234,000 individuals** in the district – including **56,000 children** and **90,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **288,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **48,000 consumers** in the district received approximately **$3.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$65 per family in 2011**.
- **Up to 38,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **304,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **61,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **57,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 24th Congressional District of California

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Capps's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **11,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,400 seniors** in the district received prescription drug discounts worth **$13.1 million**, an average discount of **$610 per person in 2011, $720 in 2012**, and **$500 thus far in 2013**.
- **113,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **181,000 individuals** in the district – including **31,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **208,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **37,100 consumers** in the district received approximately **$2.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$65 per family in 2011**.
- **Up to 36,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **216,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **126,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **58,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 33rd Congressional District of California

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Waxman's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,000 seniors** in the district received prescription drug discounts worth **$17.5 million**, an average discount of **$650 per person in 2011, $740 in 2012**, and **$550 thus far in 2013**.
- **126,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **236,000 individuals** in the district – including **48,000 children** and **99,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **324,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **48,400 consumers** in the district received approximately **$3.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$65 per family in 2011**.
- **Up to 31,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **329,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **63,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **128,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of Colorado

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. DeGette's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,900 seniors** in the district received prescription drug discounts worth **$9.3 million**, an average discount of **$570 per person in 2011, $660 in 2012**, and **$1,120 thus far in 2013**.
- **110,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **192,000 individuals** in the district – including **36,000 children** and **80,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **201,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **27,900 consumers** in the district received approximately **$5.2 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$134 per family in 2012** and **$227 per family in 2011**.
- **Up to 37,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **247,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **121,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **55,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 4th Congressional District of Colorado

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Gardner's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 4,700 seniors** in the district received prescription drug discounts worth **$6.3 million**, an average discount of **$600 per person in 2011, $660 in 2012**, and **$990 thus far in 2013**.
- **81,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **206,000 individuals** in the district – including **53,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **215,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **30,000 consumers** in the district received approximately **$5.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$134 per family in 2012** and **$227 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **265,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **100,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **58,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 12th Congressional District of Florida

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Bilirakis's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 10,200 seniors** in the district received prescription drug discounts worth **$12.9 million**, an average discount of **$550 per person in 2011, $660 in 2012**, and **$720 thus far in 2013**.
- **153,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **190,000 individuals** in the district – including **41,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **164,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 53,500 consumers** in the district received approximately **$7.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$132 per family in 2012** and **$168 per family in 2011**.
- **Up to 36,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **216,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 97,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **45,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 14th Congressional District of Florida

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Castor's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,900 seniors** in the district received prescription drug discounts worth **$8.2 million**, an average discount of **$610 per person in 2011, $690 in 2012**, and **$840 thus far in 2013**.
- **87,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **152,000 individuals** in the district – including **29,000 children** and **65,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **134,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 43,000 consumers** in the district received approximately **$6.1 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$132 per family in 2012** and **$168 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **181,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 156,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 11th Congressional District of Georgia

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Gingrey's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,300 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,800 seniors** in the district received prescription drug discounts worth **$12.6 million**, an average discount of **$620 per person in 2011, $760 in 2012**, and **$900 thus far in 2013**.
- **86,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **195,000 individuals** in the district – including **47,000 children** and **78,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **169,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 19,900 consumers** in the district received approximately **$2.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$82 per family in 2012** and **$134 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **248,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 129,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **45,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 12th Congressional District of Georgia

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Barrow's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **10,400 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,800 seniors** in the district received prescription drug discounts worth **$11 million**, an average discount of **$560 per person in 2011, $780 in 2012**, and **$790 thus far in 2013**.
- **109,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **161,000 individuals** in the district – including **36,000 children** and **67,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **114,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,500 consumers** in the district received approximately **$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$82 per family in 2012** and **$134 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **176,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 129,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **20,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of Iowa

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Braley's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,100 seniors** in the district received prescription drug discounts worth **$12.5 million**, an average discount of **$610 per person in 2011, $680 in 2012**, and **$790 thus far in 2013**.
- **129,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **238,000 individuals** in the district – including **51,000 children** and **95,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **179,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **7,100 consumers** in the district received approximately **$400,000 in insurance company rebates** in 2012 and 2011 – an average rebate of **$111 per family in 2012** and **$100 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **278,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **61,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **50,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of Illinois

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Rush's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,300 seniors** in the district received prescription drug discounts worth **$8.6 million**, an average discount of **$620 per person in 2011, $730 in 2012**, and **$920 thus far in 2013**.
- **121,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **172,000 individuals** in the district – including **34,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **150,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **14,800 consumers** in the district received approximately **$3.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$52 per family in 2012** and **$380 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **206,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **103,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **22,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 9th Congressional District of Illinois

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Schakowsky's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,700 seniors** in the district received prescription drug discounts worth **$13.8 million**, an average discount of **$730 per person in 2011, $800 in 2012**, and **$750 thus far in 2013**.
- **102,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **201,000 individuals** in the district – including **39,000 children** and **84,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **188,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **17,300 consumers** in the district received approximately **$3.9 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$52 per family in 2012** and **$380 per family in 2011**.
- **Up to 36,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **251,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **99,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **42,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 15th Congressional District of Illinois

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Shimkus's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 10,300 seniors** in the district received prescription drug discounts worth **$15.4 million**, an average discount of **$660 per person in 2011, $710 in 2012**, and **$1,010 thus far in 2013**.
- **140,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **193,000 individuals** in the district – including **40,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **165,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **16,700 consumers** in the district received approximately **$3.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$52 per family in 2012** and **$380 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **219,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **77,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **38,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 16th Congressional District of Illinois

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Kinzinger's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,700 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,900 seniors** in the district received prescription drug discounts worth **$14.3 million**, an average discount of **$650 per person in 2011, $680 in 2012**, and **$890 thus far in 2013**.
- **128,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **205,000 individuals** in the district – including **45,000 children** and **82,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **184,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **17,700 consumers** in the district received approximately **$4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$52 per family in 2012** and **$380 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **245,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **70,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 4th Congressional District of Kansas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Pompeo's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,400 seniors** in the district received prescription drug discounts worth **$13.2 million**, an average discount of **$600 per person in 2011, $730 in 2012**, and **$820 thus far in 2013**.
- **111,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **202,000 individuals** in the district – including **50,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **167,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 20,100 consumers** in the district received approximately **$2 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$71 per family in 2012** and **$91 per family in 2011**.
- **Up to 45,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **239,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 93,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **35,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of Kentucky

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop-shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Whitfield's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 15,300 seniors** in the district received prescription drug discounts worth **$21.7 million**, an average discount of **$580 per person in 2011, $800 in 2012**, and **$460 thus far in 2013**.
- **155,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **179,000 individuals** in the district – including **37,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **124,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **39,700 consumers** in the district received approximately **$4.7 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$100 per family in 2012** and **$114 per family in 2011**.
- **Up to 40,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **193,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **105,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 2nd Congressional District of Kentucky

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop-shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Guthrie's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,700 seniors** in the district received prescription drug discounts worth **$17.5 million**, an average discount of **$560 per person in 2011, $760 in 2012**, and **$580 thus far in 2013**.
- **135,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **198,000 individuals** in the district – including **42,000 children** and **81,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **140,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **43,900 consumers** in the district received approximately **$5.2 million in insurance company rebates** in 2012 and 2011– an average rebate of **$100 per family in 2012** and **$114 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **221,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **92,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **32,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of Louisiana

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Scalise's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 13,600 seniors** in the district received prescription drug discounts worth **$17 million**, an average discount of **$570 per person in 2011, $650 in 2012**, and **$740 thus far in 2013**.
- **125,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **200,000 individuals** in the district – including **43,000 children** and **82,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **175,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 15,100 consumers** in the district received approximately **$1.2 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$50 per family in 2012** and **$94 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **239,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 112,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **51,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of Louisiana

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Cassidy's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 10,500 seniors** in the district received prescription drug discounts worth **$13.4 million**, an average discount of **$570 per person in 2011, $740 in 2012**, and **$810 thus far in 2013**.
- **101,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **215,000 individuals** in the district – including **47,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **190,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,200 consumers** in the district received approximately **$1.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$50 per family in 2012** and **$94 per family in 2011**.
- **Up to 45,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **267,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 99,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **45,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 3rd Congressional District of Maryland

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop-shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Sarbanes's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,600 seniors** in the district received prescription drug discounts worth **$11.6 million**, an average discount of **$580 per person in 2011, $830 in 2012**, and **$1,020 thus far in 2013**.
- **121,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **224,000 individuals** in the district – including **47,000 children** and **94,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **180,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **19,300 consumers** in the district received approximately **$5.3 million in insurance company rebates** in 2012 and 2011– an average rebate of **$143 per family in 2012** and **$340 per family in 2011**.
- **Up to 38,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **264,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **70,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **42,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of Michigan

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Upton's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,700 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,100 seniors** in the district received prescription drug discounts worth **$11.4 million**, an average discount of **$590 per person in 2011, $740 in 2012**, and **$850 thus far in 2013**.
- **131,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **197,000 individuals** in the district – including **43,000 children** and **80,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **163,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,000 consumers** in the district received approximately **$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$138 per family in 2012** and **$214 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **223,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 84,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **36,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 8th Congressional District of Michigan

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Rogers's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,800 seniors** in the district received prescription drug discounts worth **$10.3 million**, an average discount of **$590 per person in 2011, $780 in 2012**, and **$560 thus far in 2013**.
- **105,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **225,000 individuals** in the district – including **50,000 children** and **91,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **197,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 18,200 consumers** in the district received approximately **$2.7 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$138 per family in 2012** and **$214 per family in 2011**.
- **Up to 40,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **272,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 63,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 12th Congressional District of Michigan

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Dingell's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,200 seniors** in the district received prescription drug discounts worth **$7.9 million**, an average discount of **$580 per person in 2011, $750 in 2012**, and **$540 thus far in 2013**.
- **107,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **206,000 individuals** in the district – including **40,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **183,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,700 consumers** in the district received approximately **$2.5 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$138 per family in 2012** and **$214 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **252,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 75,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 7th Congressional District of Missouri

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Long's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 10,100 seniors** in the district received prescription drug discounts worth **$13.7 million**, an average discount of **$600 per person in 2011, $680 in 2012**, and **$770 thus far in 2013**.
- **141,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **194,000 individuals** in the district – including **40,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **139,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 68,900 consumers** in the district received approximately **$9.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$72 per family in 2012** and **$173 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **225,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 126,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 3rd Congressional District of Mississippi

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Harper's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,000 seniors** in the district received prescription drug discounts worth **$11.7 million**, an average discount of **$610 per person in 2011, $650 in 2012**, and **$890 thus far in 2013**.
- **132,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **184,000 individuals** in the district – including **40,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **153,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 16,400 consumers** in the district received approximately **$4.4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$140 per family in 2012** and **$329 per family in 2011**.
- **Up to 44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **217,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 114,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **44,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of North Carolina

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Butterfield's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **8,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 7,300 seniors** in the district received prescription drug discounts worth **$9.7 million**, an average discount of **$600 per person in 2011, $680 in 2012**, and **$1,110 thus far in 2013**.
- **130,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **150,000 individuals** in the district – including **25,000 children** and **71,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **138,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 13,200 consumers** in the district received approximately **$1.7 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$87 per family in 2012** and **$158 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **155,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 137,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **33,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 2nd Congressional District of North Carolina

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Ellmers's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,400 seniors** in the district received prescription drug discounts worth **$11.3 million**, an average discount of **$600 per person in 2011, $670 in 2012**, and **$990 thus far in 2013**.
- **119,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **197,000 individuals** in the district – including **52,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **142,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 17,300 consumers** in the district received approximately **$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$87 per family in 2012** and **$158 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **207,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 109,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **38,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 2nd Congressional District of Nebraska

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Terry's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,000 seniors** in the district received prescription drug discounts worth **$8.3 million**, an average discount of **$650 per person in 2011, $700 in 2012**, and **$1,010 thus far in 2013**.
- **75,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **183,000 individuals** in the district – including **45,000 children** and **71,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **136,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 15,500 consumers** in the district received approximately **$2.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$82 per family in 2012** and **$215 per family in 2011**.
- **Up to 39,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **225,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 72,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **36,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of New Jersey

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Pallone's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,200 young adults** in the district now have health insurance through their parents plan.
- **More than 13,300 seniors** in the district received prescription drug discounts worth **$21.8 million**, an average discount of **$770 per person in 2011, $990 in 2012**, and **$610 thus far in 2013**.
- **110,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **211,000 individuals** in the district – including **46,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **187,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **18,300 consumers** in the district received approximately **$1.5 million in insurance company rebates** in 2011 and 2012 – an average rebate of **$104 per family in 2012** and **$300 per family in 2011**.
- Up to **40,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **262,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **110,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **24,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 7th Congressional District of New Jersey

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Lance's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **4,100 young adults** in the district now have health insurance through their parents plan.
- **More than 16,400 seniors** in the district received prescription drug discounts worth **$26.1 million**, an average discount of **$760 per person in 2011, $970 in 2012**, and **$700 thus far in 2013**.
- **126,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **256,000 individuals** in the district – including **65,000 children** and **99,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **240,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **22,200 consumers** in the district received approximately **$1.9 million in insurance company rebates** in 2011 and 2012 – an average rebate of **$104 per family in 2012** and **$300 per family in 2011**.
- Up to **44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **329,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **56,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **42,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 3rd Congressional District of New Mexico

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent, one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Lujan's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,700 young adults** in the district now have health insurance through their parents plan.
- **More than 5,600 seniors** in the district received prescription drug discounts worth **$7.3 million**, an average discount of **$480 per person in 2011, $810 in 2012**, and **$880 thus far in 2013**.
- **105,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **147,000 individuals** in the district – including **32,000 children** and **60,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **122,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead.
- Up to **43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **163,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **147,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **33,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 16th Congressional District of New York

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Engel's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,400 seniors** in the district received prescription drug discounts worth **$12.6 million**, an average discount of **$690 per person in 2011, $750 in 2012**, and **$620 thus far in 2013**.
- **108,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **195,000 individuals** in the district – including **45,000 children** and **82,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **207,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **38,200 consumers** in the district received approximately **$4.5 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$92 per family in 2012** and **$138 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **239,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **77,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **29,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 20th Congressional District of New York

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Tonko's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,100 seniors** in the district received prescription drug discounts worth **$16 million**, an average discount of **$610 per person in 2011, $650 in 2012**, and **$290 thus far in 2013**.
- **124,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **223,000 individuals** in the district – including **42,000 children** and **95,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **227,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **43,600 consumers** in the district received approximately **$5.1 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$92 per family in 2012** and **$138 per family in 2011**.
- **Up to 37,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **262,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **49,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 5th Congressional District of Ohio

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Latta's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,200 young adults** in the district now have health insurance through their parents' plan.
- **More than 13,100 seniors** in the district received prescription drug discounts worth **$18 million**, an average discount of **$520 per person in 2011, $820 in 2012**, and **$480 thus far in 2013**.
- **127,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **221,000 individuals** in the district – including **51,000 children** and **89,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **187,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 9,900 consumers** in the district received approximately **$800,000 in insurance company rebates** in 2012 and 2011 – an average rebate of **$133 per family in 2012** and **$139 per family in 2011**.
- **Up to 41,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **259,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 68,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **27,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of Ohio

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Johnson's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 15,200 seniors** in the district received prescription drug discounts worth **$20.8 million**, an average discount of **$510 per person in 2011, $810 in 2012**, and **$860 thus far in 2013**.
- **162,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **186,000 individuals** in the district – including **38,000 children** and **76,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **149,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 8,300 consumers** in the district received approximately **$700,000 in insurance company rebates** in 2012 and 2011 – an average rebate of **$133 per family in 2012** and **$139 per family in 2011**.
- **Up to 38,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **206,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 88,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **22,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 2nd Congressional District of Oregon

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Walden's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,400 young adults** in the district now have health insurance through their parents' plan.
- **More than 9,000 seniors** in the district received prescription drug discounts worth **$10.7 million**, an average discount of **$540 per person in 2011, $600 in 2012**, and **$590 thus far in 2013**.
- **152,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **187,000 individuals** in the district – including **37,000 children** and **79,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **195,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **4,300 consumers** in the district received approximately **$1.4 million in insurance company rebates** in 2012 and 2011-an average rebate of **$206 per family in 2012** and **$368 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **206,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **135,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **51,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 14th Congressional District of Pennsylvania

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Doyle's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 13,400 seniors** in the district received prescription drug discounts worth **$20.1 million**, an average discount of **$600 per person in 2011, $800 in 2012**, and **$840 thus far in 2013**.
- **134,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **188,000 individuals** in the district – including **26,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **147,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 29,200 consumers** in the district received approximately **$3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$77 per family in 2012** and **$165 per family in 2011**.
- **Up to 31,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **215,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 71,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **34,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 16th Congressional District of Pennsylvania

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Pitts's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 11,800 seniors** in the district received prescription drug discounts worth **$18 million**, an average discount of **$700 per person in 2011, $750 in 2012**, and **$610 thus far in 2013**.
- **113,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **191,000 individuals** in the district – including **41,000 children** and **78,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **152,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 29,600 consumers** in the district received approximately **$3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$77 per family in 2012** and **$165 per family in 2011**.
- **Up to 43,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **225,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 86,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **32,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 18th Congressional District of Pennsylvania

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Murphy's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **3,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 15,300 seniors** in the district received prescription drug discounts worth **$23.1 million**, an average discount of **$620 per person in 2011, $800 in 2012**, and **$730 thus far in 2013**.
- **133,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **230,000 individuals** in the district – including **45,000 children** and **97,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **181,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 35,800 consumers** in the district received approximately **$3.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$77 per family in 2012** and **$165 per family in 2011**.
- **Up to 35,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **266,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 49,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 7th Congressional District of Tennessee

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Blackburn's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,000 seniors** in the district received prescription drug discounts worth **$10 million**, an average discount of **$580 per person in 2011, $610 in 2012**, and **$960 thus far in 2013**.
- **116,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **191,000 individuals** in the district – including **50,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **181,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 27,900 consumers** in the district received approximately **$4 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$69 per family in 2012** and **$201 per family in 2011**.
- **Up to 44,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **208,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 91,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **39,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 4th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Hall's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 8,100 seniors** in the district received prescription drug discounts worth **$10.6 million**, an average discount of **$580 per person in 2011, $660 in 2012**, and **$1,070 thus far in 2013**.
- **135,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **168,000 individuals** in the district – including **37,000 children** and **69,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **147,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 43,000 consumers** in the district received approximately **$6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$95 per family in 2012** and **$187 per family in 2011**.
- **Up to 42,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **195,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 140,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **30,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 6th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Barton's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,100 young adults** in the district now have health insurance through their parents' plan.
- **More than 6,400 seniors** in the district received prescription drug discounts worth **$8.7 million**, an average discount of **$610 per person in 2011, $680 in 2012**, and **$890 thus far in 2013**.
- **85,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **188,000 individuals** in the district – including **46,000 children** and **72,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **183,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 48,100 consumers** in the district received approximately **$6.8 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$95 per family in 2012** and **$187 per family in 2011**.
- **Up to 47,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **241,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 142,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **40,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 22nd Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Olson's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,500 seniors** in the district received prescription drug discounts worth **$8 million**, an average discount of **$680 per person in 2011, $730 in 2012**, and **$660 thus far in 2013**.
- **65,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **212,000 individuals** in the district – including **61,000 children** and **77,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **208,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 54,100 consumers** in the district received approximately **$7.6 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$95 per family in 2012** and **$187 per family in 2011**.
- **Up to 49,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **279,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 127,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **35,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 26th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Burgess's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **9,500 young adults** in the district now have health insurance through their parents' plan.
- **More than 4,900 seniors** in the district received prescription drug discounts worth **$7 million**, an average discount of **$650 per person in 2011, $720 in 2012**, and **$850 thus far in 2013**.
- **55,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **232,000 individuals** in the district – including **66,000 children** and **86,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **230,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 59,300 consumers** in the district received approximately **$8.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$95 per family in 2012** and **$187 per family in 2011**.
- Up to **48,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **305,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 90,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **44,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 29th Congressional District of Texas

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Green's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **11,000 young adults** in the district now have health insurance through their parents' plan.
- **More than 3,000 seniors** in the district received prescription drug discounts worth **$3.6 million**, an average discount of **$530 per person in 2011, $570 in 2012**, and **$1,090 thus far in 2013**.
- **58,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **96,000 individuals** in the district – including **22,000 children** and **36,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **89,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 24,600 consumers** in the district received approximately **$3.5 million in insurance company rebates** in 2011 and 2012 – an average rebate of **$95 per family in 2012** and **$187 per family in 2011**.
- **Up to 55,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **121,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 261,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **12,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 4th Congressional District of Utah

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Matheson's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **5,600 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,200 seniors** in the district received prescription drug discounts worth **$7.2 million**, an average discount of **$600 per person in 2011, $730 in 2012**, and **$1,020 thus far in 2013**.
- **64,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **207,000 individuals** in the district – including **64,000 children** and **73,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **213,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 34,700 consumers** in the district received approximately **$2.1 million in insurance company rebates** in 2011 and 2012 – an average rebate of **$85 per family in 2011** and **$85 per family in 2012**.
- **Up to 53,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **268,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 113,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **31,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in the 9th Congressional District of Virginia

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. Griffith's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **6,800 young adults** in the district now have health insurance through their parents' plan.
- **More than 12,200 seniors** in the district received prescription drug discounts worth **$17.7 million**, an average discount of **$620 per person in 2011, $770 in 2012**, and **$840 thus far in 2013**.
- **162,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **189,000 individuals** in the district – including **32,000 children** and **81,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **168,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, **over 18,600 OR 54,000 consumers** in the district received approximately **$4.3 million in insurance company rebates** in 2012 and 2011 – an average rebate of **$88 per family in 2012** and **$115 per family in 2011**.
- **Up to 34,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **214,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **Up to 93,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition.[1] In addition, the **41,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

[1] Presently, coverage for many of these individuals – those with incomes below 100% of the federal poverty level – is in doubt. The ACA provides for the fully funded expansion of Medicaid to cover these individuals. However, the Supreme Court has ruled that the decision to take these funds and provide this coverage is at the discretion of the Governor and the Legislature. To date, the Governor and Legislature have not approved the expansion of Medicaid to these individuals, putting their access to affordable coverage in doubt.

July 2013

Benefits of the Health Care Reform Law in Vermont

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in the State of Vermont, which Rep. Welch represents. As a result of the law:

- **5,000 young adults** in state now have health insurance through their parents' plan.
- **More than 6,100 seniors** in the state received prescription drug discounts worth **$9.4 million**, an average discount of **$720 per person in 2011, $780 in 2012**, and **$1,000 thus far in 2013**.
- **118,000 seniors** in the state are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **175,000 individuals** in the state – including **30,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **163,000 individuals** in the state are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **5,200 consumers** in the state received approximately **$2.5 million in insurance company rebates** in 2012 and 2011-an average rebate of **$58 per family in 2012** and **$807 per family in 2011**.
- **Up to 31,000 children** in the state with preexisting health conditions can no longer be denied coverage by health insurers.
- **201,000 individuals** in the state now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **41,000 individuals** in the state who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **32,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 5th Congressional District of Washington

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. McMorris Rodgers's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,900 young adults** in the district now have health insurance through their parents' plan.
- **More than 5,600 seniors** in the district received prescription drug discounts worth **$7.5 million**, an average discount of **$620 per person in 2011, $660 in 2012**, and **$1,070 thus far in 2013**.
- **113,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **180,000 individuals** in the district – including **36,000 children** and **75,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **167,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **700 consumers** in the district received approximately **$100,000 in insurance company rebates** in 2012 and 2011-an average rebate of **$512 per family in 2012** and **$185 per family in 2011**.
- **Up to 36,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **203,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **89,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **45,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

July 2013

Benefits of the Health Care Reform Law in the 1st Congressional District of West Virginia

Committees on Energy and Commerce, Ways and Means, and Education and the Workforce
Democratic Staff Report

The landmark Affordable Care Act (ACA) began delivering important new benefits and protections to tens of millions of American families almost immediately after it was signed into law by President Obama. But the largest benefits of the law will become available to consumers on October 1, 2013, when health insurance marketplaces open in all 50 states. These marketplaces will offer individuals, families, and small businesses an efficient, transparent one-stop shop to compare health insurance policies, receive financial assistance, and sign up for high-quality, affordable, and secure insurance coverage.

This fact sheet summarizes new data on the significant benefits of the health care reform law in Rep. McKinley's district. It also provides the first picture of the impacts of the law in districts redrawn or newly created following the 2010 Census. As a result of the law:

- **7,300 young adults** in the district now have health insurance through their parents' plan.
- **More than 13,700 seniors** in the district received prescription drug discounts worth **$21.4 million**, an average discount of **$670 per person in 2011, $860 in 2012**, and **$310 thus far in 2013**.
- **128,000 seniors** in the district are now eligible for Medicare preventive services without paying any co-pays, coinsurance, or deductible.
- **162,000 individuals** in the district – including **29,000 children** and **69,000 women** – now have health insurance that covers preventive services without any co-pays, coinsurance, or deductible.
- **140,000 individuals** in the district are saving money due to ACA provisions that prevent insurance companies from spending more than 20% of their premiums on profits and administrative overhead. Because of these protections, over **5,700 consumers** in the district received approximately **$1.3 million in insurance company rebates** in 2012 and 2011-an average rebate of **$132 per family in 2012** and **$374 per family in 2011**.
- **Up to 29,000 children** in the district with preexisting health conditions can no longer be denied coverage by health insurers.
- **179,000 individuals** in the district now have insurance that cannot place lifetime limits on their coverage and will not face annual limits on coverage starting in 2014.
- **84,000 individuals** in the district who lack health insurance will have access to quality, affordable coverage without fear of discrimination or higher rates because of a preexisting health condition. In addition, the **19,000 individuals** who currently purchase private health insurance on the individual or small group market will have access to more secure, higher quality coverage and many will be eligible for financial assistance.

Ms. DEGETTE. Thank you so much.

I would like to share some of the information on the benefits in my district, Denver, Colorado. Already in my district, the Affordable Care Act is providing 8,000 young adults with healthcare coverage through their parents' plan. More than 6,900 seniors in my district have gotten drug discounts worth $9.3 million. Almost 200,000 of my constituents now have health insurance that covers preventative service without copays. Hundreds of thousands of my constituents with private insurance are saving money due to the ACA provisions that limit insurers' administrative overhead costs. And when the law finally goes fully into effect, over 120,000 of my constituents who currently don't have health insurance will be able to get that insurance without fear of discrimination or higher rates because of a preexisting condition.

So even if you disagree with the law, it is important that you know how the Affordable Care Act's benefits are already helping our constituents.

Now, Madam Chairman, we have had many hearings on this law, many in our Oversight and Investigations Subcommittee. And one of the common concerns that we have already heard today in the opening statements is that premiums will be too high. We are beginning to get answers on this. An HHS analysis received earlier this month found that in the States for which data are available the lowest cost Silver plan in the individual market in 2014 will cost on average 18 percent less than the rate predicted by the Congressional Budget Office. On the small group market, the average premium that small employers will pay is again 18 percent lower than the same plan would cost absent the Affordable Care Act.

In Colorado, similarly, the lowest cost Silver plans are on average 18 percent less than the status quo. So it seems like every day we are getting more and more information about a new State where the rate review process and competition are causing insurers to lower their premiums even more than expected. And of course the actual cost of these plans will be even lower for many citizens once the Affordable Care Act's tax credits go into effect.

Now, Administrator Tavenner, I know you have got to be pleased with this. But as you know, your job is not yet done. In 2 months, the data systems for the insurance exchanges will go live. I don't think everything is going to go completely smoothly; it certainly didn't with Part D. But I want to hear what the administration is doing to deal with all of these foreseeable problems and developing systems to deal with the unexpected problems.

I think we all have legitimate questions. We are happy to have you here today, and I look forward to hearing your answers to all of them.

Thank you very much, Madam Chair. I yield back.

Ms. BLACKBURN. Gentlelady yields back.

I would like to welcome our witness today, Marilyn Tavenner. She is currently the Administrator for the Centers for Medicare and Medicaid Services. Previously, she was the Principal Deputy Administrator for CMS. In this role, she served as the agency's second-ranking official, overseeing policy development and implementation, as well as management and operations.

Ms. Tavenner, you are recognized for 5 minutes.

STATEMENT OF MARILYN TAVENNER, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. TAVENNER. Thank you, Vice Chair. I would like to thank Chairman Upton. I would like to thank you.

Ms. BLACKBURN. Ms. Tavenner, if you will check your microphone.

Ms. TAVENNER. I have it on. Can you hear me now? I didn't have it close enough?

Mrs. BLACKBURN. Let's pull it a little closer.

Ms. TAVENNER. All right. How about that?

Mrs. BLACKBURN. That is much better. Thank you.

Ms. TAVENNER. All right. I would like to thank you, Chairman Upton, and Ranking Member Waxman, and members of the committee for inviting me here today to update you on the implementation of the Affordable Care Act. I am pleased to say that you are right, 60 days from now is the beginning of open enrollment when Americans will be able to compare and enroll in affordable healthcare coverage, and that implementation is on track.

This is a large and complicated endeavor that I am proud to lead and every decision is being made by my prior work experience. My clinical perspective from my early days as a staff nurse keeps in the forefront of my mind the reason why we are here: that patients deserve better, higher performing delivery systems that they can afford.

My perspective on business comes from my days as a hospital CEO, where I not only managed complicated systems that included the merging of hospitals, but where I had patients come to see me to tell me that they didn't have health insurance. And these were hard-working individuals with families who could not afford their hospital bills. They had been unable to get insurance or they were unable to afford insurance. So I would sit down with each person that came to me and we would work out a payment plan, sometimes $5 a month, sometimes $10 a month, sometimes a 23-year plan, a 30-year plan, because I couldn't stand to see that family have to file a medical bankruptcy. Today, I would continue to help everyone who asked for my help, but the concern were those who didn't know to ask.

Finally, I have the government perspective. From my work as Virginia's Health and Human Resources Secretary and obviously the last 3–1/2 years at CMS. I am extremely fortunate to have a strong and dedicated team at CMS who have experience in operating programs that cover millions of Americans today and also have experience in implementing large transformations, including programs such as Medicare Advantage, CHIP, and Part D, all of which are now quite popular.

I consider partnerships as essential to my leadership role at CMS, and have made it a point to work with Congress and partner with all the various stakeholders in the healthcare community. Over the last 3 years, I have worked and listened to our partners, including States, hospitals, health insurers, providers, employers, and consumers. Implementation of the Affordable Care Act depends on the hard work of thousands of people across the country, and we are all in this together to make it a success.

I am motivated and energized to fully implement the Affordable Care Act. I am thinking about those staff nurses now who, thanks to the law, are able to focus on patient care and coordination, and those hospital CEOs who won't have to set people on payment plans. Instead they will be able to get people enrolled in health insurance, something far more secure and valuable.

I am thinking about the policymakers and those in government who will benefit from the new tools from our modernized systems and improved data initiatives. Even before we begin enrollment on October 1, we are already seeing changes in the healthcare delivery system through improved accountability and coordination. Growth in national health expenditures for the last 3 years is lower than any time in the last 50. We are observing a decrease in the rate of patients returning to the hospitals after being discharged. Millions of Medicare beneficiaries are now getting better care from ACOs whose bottom line benefits from keeping them healthy.

From health insurance markets we are seeing changes through improved transparency and competition. In States like California, Maryland, New York, Washington, new competition and new choices are pushing costs down. New York announced average premiums that were at least 50 percent lower next year than they are now. And I can go on and on.

CMS is ready for October 1, and we are motivated and well prepared for the hard work ahead. We are ready and on time over the next 60 days to refine our systems and get the word out. We are proud to meet this challenge, and we are proud to help our fellow Americans.

Today, I am focused on answering your questions. I know you are returning to your districts soon, so I hope today we will engage in a dialogue and that my answers can help you respond to your constituents' concerns. I look forward to working with you today and in the future. Thank you.

[The prepared statement of Ms. Tavenner follows:]

STATEMENT OF

MARILYN TAVENNER

ADMINISTRATOR,

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE

AUGUST 1, 2013

Testimony of Marilyn Tavenner on the Implementation of the Affordable Care Act
House Committee on Energy & Commerce
August 1, 2013

Good morning, Chairman Upton, Ranking Member Waxman, and members of the Committee. Thank you for the opportunity to speak about the work at the Centers for Medicare & Medicaid Services (CMS) implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans the additional tools to make informed choices about their health insurance. In March 2010, Congress passed and President Obama signed into law the Affordable Care Act, putting in place comprehensive reforms to improve access to affordable health insurance for all Americans and protect consumers from abusive insurance company practices. Millions of Americans have already benefited from this law, and two months from today, the Health Insurance Marketplace will be open for business, giving consumers an easy way to compare and enroll in more affordable health insurance coverage.

Reducing Costs and Improving Health Care Quality

In addition to expanding coverage, CMS is implementing reforms in the Affordable Care Act that will make the health care delivery system work better for consumers. These reforms include incentives and tools to help providers avoid costly mistakes and preventable readmissions, keep patients healthy, and make sure Medicare and Medicaid payments reward excellent care and not simply the provision of more services. These payment changes and investments will strengthen our health care system, ensuring quality care for generations to come – not just for Medicare and Medicaid beneficiaries, but for all patients that depend on our health care system.

There is growing evidence that these reforms are working for the entire system, keeping costs low for not only Medicare and Medicaid beneficiaries, but also for consumers and employers shopping for coverage in the private health insurance market. Affordable Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per

beneficiary[1] without reducing benefits for beneficiaries. Growth in national health expenditures over the past three years was lower than any time over the last 50 years. We are also observing a decrease in the rate of patients returning to the hospital after being discharged. After fluctuating between 18.5 percent and 19.5 percent for the past five years, the Medicare 30-day all-cause readmission rate dropped to approximately 18 percent in the final quarter of 2012. This decrease is an early sign that our payment and delivery reforms are having an impact. Growing numbers of physicians and other providers are participating in new payment initiatives that reward higher-quality and lower-cost care. In 2012, we launched the first cohort of Medicare Accountable Care Organizations (ACOs), groups of providers working together to promote accountability for a patient population and redesigning care processes for high quality and efficient service delivery. To date, more than 240 Medicare ACOs are in operation, available in almost every State. A health care delivery system that rewards quality over volume will help make health care more affordable for all consumers.

Improving Access to Health Insurance: The Health Insurance Marketplace

Millions of Americans currently buy coverage through the individual market, in many cases at a much higher cost than they would see as part of a larger pool. Additionally, over 40 million Americans under the age of 65 do not currently have health insurance, sometimes because the cost of insurance is too high or because they have been excluded from the private insurance market because of pre-existing conditions.

Establishing the Marketplaces

To give Americans a better way to shop for coverage, the Affordable Care Act directs states to establish State-based Marketplaces by January 1, 2014. In states electing not to establish and operate such a Marketplace, the Affordable Care Act directs the Federal Government to establish and operate a Marketplace in the state, referred to as a Federally-facilitated Marketplace. A State may also choose to partner with the Federal Government to operate a Marketplace. The Marketplace will provide consumers with access to health care coverage through private,

[1] ASPE Issue Brief: "*Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows*" for full report please visit: http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm

qualified health plans, and consumers seeking financial assistance may qualify for insurance affordability programs.

Since the passage of the Affordable Care Act, CMS has been hard at work to design, build, and test secure systems that ensure Americans are able to enroll in affordable health care coverage through the Marketplace. CMS has already completed the majority of the development of the services required to support open enrollment beginning on October 1, 2013 for coverage starting January 1, 2014. CMS has been conducting systems tests since October 2012 and will complete end-to-end testing before open enrollment begins. CMS is also reviewing applications from issuers to offer qualified health plans in the Federally-facilitated Marketplaces; CMS has received qualified health plan submissions from more than 120 issuers.

When consumers visit the Marketplace through HealthCare.gov beginning on October 1, 2013, they will experience a new way to shop for health coverage. There, they can fill out one application to purchase coverage through a qualified health plan, to qualify for premium tax credits and reduced cost sharing, or to apply for coverage through Medicaid or the Children's Health Insurance Program (CHIP).[2]

The online version of the application will be a dynamic experience that shortens the application process based on individuals' responses. The paper application for individuals is three pages, and the application for families is seven pages. These applications are much shorter than industry standards for health insurance applications today. The paper application was simplified and tailored to meet personal situations based on important feedback from consumer groups.[3] CMS is also developing a variety of information sources to support consumers as they fill out the streamlined application, including through HealthCare.gov and a toll-free call center, which is already up and running.

[2] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[3] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-04-30.html

During the application process, millions of Americans may learn that they or their family member qualifies for coverage under their state's Medicaid program. The Medicaid program provides care for millions of individuals, and plays an important role in providing coverage for low-income children, pregnant women, people with disabilities and seniors needing long term care services and supports. Under the Affordable Care Act, Medicaid eligibility for adult coverage will be simplified, Federal funding will increase, and millions of uninsured low-income people will gain coverage.

These millions of Americans will be able to access and apply for Medicaid or the State Children's Health Insurance Program through the Health Insurance Marketplace in their state. They will fill out the same basic application to help determine what types of coverage they and their family qualify for. CMS has worked with states to ensure eligibility, enrollment and renewal processes will be modernized and streamlined.

In particular, CMS has worked with states to implement the simplified financial eligibility standard set forth under the Affordable Care Act by relying on a single Modified Adjusted Gross Income (MAGI) standard for determining eligibility for most Medicaid and CHIP enrollees and by consolidating eligibility categories. The new MAGI rules and enrollment procedures are aligned with those that will apply for determining eligibility for an advance premium tax credit in the Marketplace. Coordination with the Exchange is important to ensuring that consumers may apply for coverage and enroll in a plan through a single, streamlined process.

Making Health Insurance More Affordable

We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. While many states are still finalizing or finishing final review of their rates, some, like New York, California, Washington, Vermont, Oregon, and the District of Columbia, have released preliminary rates, and in some cases, independent experts say that these rates have been lower than expected.[4] In the eleven states for which data are

[4] http://www.zanebenefits.com/blog/bid/301885/Washington-Health-Insurance-Exchange-Rates-Lower-Than-Expected and

available, the preliminary rate for the lowest cost silver plan in the individual market in 2014 is, on average, 18 percent less expensive than the estimate based on projections by the Congressional Budget Office.[5]

This is good news for consumers. In fact, some states have released initial bids only to have insurers request to amend their bid after competitors' publically-available bids come in at lower prices. In Washington, D.C., United Health Care and Aetna both reduced their small group rates, by 10 and 5 percent, respectively.[6] In Oregon, two plans requested to lower their rates by 15 percent or more.[7]Some rates submitted to California's Marketplace, Covered California, are as much as 29 percent below the 2013 average premiums for small employer plans in California's most populous regions.[8] New York State has said on average, the approved 2014 rates for even the highest levels of coverage of plans individual consumers can purchase on New York's Health Benefits Exchange (gold and platinum) represent a 53 percent reduction compared to last year's direct-pay individual rates.[9] Furthermore, states are using their rate review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for some plans by as much as 35 percent,[10] offering consumers an even better deal on their coverage for the 2014 plan year.

In addition to the more affordable rates resulting from competition among insurers, insurance affordability programs including premium tax credits and cost-sharing reductions will help many eligible individuals and families, significantly reducing the monthly premiums paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a qualified health plan through the Marketplace, enabling consumers to purchase insurance even if they lack the ability to pay up front. Cost-sharing reductions may also lower out-of-pocket

---

http://articles.chicagotribune.com/2013-05-17/news/sns-rt-us-usa-healthcare-exchangesbre94g0sb-20130517_1_health-insurance-insurance-marketplaces-premiums

[5] ASPE Research Brief: Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected

[6] http://hbx.dc.gov/release/dc-health-link-applauds-aetna-decision-cut-rates

[7] http://www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html

[8] http://www.healthexchange.ca.gov/Documents/COVERED%20CA%20-%20Health%20Plans%20PRESS%20RELEASE%20FINAL%205%2023%2013.pdf

[9] http://www.governor.ny.gov/press/07172013-health-benefit-exchange

[10] http://www.oregonlive.com/health/index.ssf/2013/06/oregon_slashes_2014_health_ins.html

payments for deductibles, coinsurance, and copayments for certain eligible individuals and families.

The Congressional Budget Office has projected that about 85 percent of Americans who obtain coverage through the Marketplaces will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.[11] A family's eligibility for these affordability programs depends on its family size, household income, and access to other types of health coverage.

Spreading the Word

Ensuring that consumers and businesses take advantage of these reforms, the Marketplace provides user-friendly tools to learn about the benefits that the Marketplace and other Affordable Care Act reforms have to offer. This is a significant undertaking. We know quite a bit about the uninsured Americans we need to reach—many have never had health insurance, so the transaction of selecting, applying, and enrolling in health coverage will be unfamiliar to them. According to a CMS analysis of the 2011 American Community Survey,[12] 20 percent of uninsured adults have not completed high school. To effectively reach these populations about their new health insurance options, information should be provided by trusted people connected to the community in an appropriate manner.

For that reason, the Affordable Care Act authorizes, and CMS is implementing, a variety of ways to provide outreach, education, and enrollment assistance. We are leveraging forms of assistance that exist in the insurance market today, as well as new forms of assistance provided by the Affordable Care Act to help educate Americans about the options for enrolling in affordable, high quality coverage beginning on October 1, 2013. In June of this year, CMS re-launched a new consumer-focused HealthCare.gov website and the 24-hours-a-day consumer call center to help Americans prepare for open enrollment and ultimately sign up for private health insurance. The new tools will help Americans understand their choices and select the coverage that best

[11] http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

[12] Data set available: https://data.cms.gov/dataset/The-Percent-of-Estimated-Eligible-Uninsured-People/9hxb-n5xb

suits their needs when open enrollment in the Marketplace begins October 1.[13] Until the start of open enrollment, the Marketplace call center will provide educational information, and beginning October 1, 2013, it will assist consumers with application completion and plan selection. I am pleased to report that we have had thousands of consumers contact us via live web chat or our toll free number and over 1 million visitors to HealthCare.gov since its re-launch in June. We are also seeing states begin their marketing efforts to help spread the word on the importance of insurance, especially for young adults. States are tailoring their message to specific audiences and the populations of their states. Recent news reports have highlighted the unique ways Oregon, Kentucky, Colorado and Connecticut plan to enroll consumers in their Marketplaces.[14] As with the roll-out of expanded healthcare coverage options, such as Medicare Part D and CHIP, CMS expects that other Federal agency partners and members of the private sector will be involved in efforts to reach, engage, and assist potential enrollees.

In addition to outreach and education through HealthCare.gov, our toll free number, and state outreach efforts, consumers in the Marketplace will be able to get in-person help from Navigators and similar in-person assisters, who will provide information to consumers about health insurance, the Marketplace, qualified health plans, and public programs including Medicaid and CHIP. Last month, CMS finalized a rule outlining the standards for Navigators, in-person assisters, and certified application counselors in the Federally-facilitated and State Partnership Marketplace. Navigators will provide accurate and impartial assistance to consumers shopping for coverage in the new Marketplace, including consumers who are not familiar with health insurance, have limited English proficiency, or are living with a disability. To be selected as Navigators, organizations must submit grant applications and undergo a thorough Federal review process. All Navigators must complete a Federal training program and pass a test to ensure they are prepared to assist consumers. State-based Marketplaces have the option of using materials developed by the Federally-facilitated Marketplace or developing their own. Grant awards for Navigators in states with Federally-facilitated and State Partnership Marketplace will

[13] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-06-24.html

[14] http://capsules.kaiserhealthnews.org/index.php/2013/07/state-insurance-exchanges-launching-tv-ads-to-encourage-enrollment/

be awarded on August 15, 2013. Additionally, where permitted by the state,[15] licensed agents and brokers, as well as online brokers and insurers, may help consumers and employers enroll in a qualified health plan through the Marketplace.

CMS is building on the lessons we learned through the efforts of earlier roll-outs of expanded health care coverage programs, such as the CHIP and the Medicare Part D drug benefit as we work to educate Americans about the Marketplace. With 60 days remaining until the beginning of open enrollment, CMS is working to provide consumers with numerous avenues to get help selecting a qualified health plan through the Marketplace.

Reforming the Health Insurance System

In addition to expanding access to affordable insurance coverage for the uninsured, the Affordable Care Act also improves the existing health insurance market. Before the Affordable Care Act, health insurance premiums had risen rapidly, straining the pocketbooks of Americans for more than a decade. Between 1999 and 2012, the cost of coverage for a family rose 172 percent.[16] These increases forced families and employers to spend more money, often for less coverage. Before the Affordable Care Act, women could be charged more for individual insurance policies simply because of their gender. For example, a 22-year-old woman could be charged 50 percent more than a 22 year-old man. Many young people and people with low incomes often could not afford health insurance, leaving millions of Americans without coverage. Before the Affordable Care Act, premium rates charged to older Americans could be more than five times the rate for younger Americans.

What We Have Already Achieved

Since the Affordable Care Act was signed into law, CMS has implemented strong consumer protections that increase insurance company accountability, give consumers more coverage options, and improve the value of that coverage. Today, more than 3.1 million additional young adults under the age of 26 are covered under their parents' plans. The families of 17.6 million

[15] Per 45 CFR 155.220

[16] Kaiser Family Foundation. Employer Health Benefits 2012 Annual Survey http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf

children with pre-existing conditions can rest more easily, because their insurance companies cannot deny their children coverage based on pre-existing conditions. Nearly 71 million Americans now have expanded access to preventive services at no additional cost through their private insurance plans, and 27 million women now have guaranteed access to additional preventive services without cost-sharing.[17] The Affordable Care Act also brought important benefits to Medicare beneficiaries. Over 6.6 million seniors saved more than $7 billion on their prescription drugs.[18] Additionally, an estimated 34 million Medicare beneficiaries received preventive care like mammograms and colonoscopies in 2012 because of the Affordable Care Act,[19] and nearly 17 million Medicare beneficiaries took advantage of at least one free preventive service in the first six months of 2013.[20] These benefits have helped to improve the lives of our neighbors and fellow Americans.

The Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs. Since the rule on rate increases was implemented,[21] the number of requests for insurance premium increases of 10 percent or more plummeted from 75 percent to an estimated 14 percent. The average premium increase for all rates in 2012 was 30 percent below what it was in 2010. Available data suggest that this slowdown in rate increases is continuing into 2013.[22] Americans have saved an estimated $1 billion on their health insurance premiums thanks to rate review.

The rate review program works in conjunction with the 80/20 rule (or the Medical Loss Ratio rule),[23] which generally requires insurance companies in the individual and small group markets to spend at least 80 percent of premiums on health care and quality improvement activities, and

---

[17] http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm
[18] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-29.html
[19] http://www.cms.gov/apps/files/Medicarereport2012.pdf
[20] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-29.html
[21] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf
[22] ASPE Research Brief: Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm
[23] MLR Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act

no more than 20 percent on administrative costs (such as executive salaries and marketing) and profits. In the large group employer market (more than 50 employees), insurers must spend 85 percent of premium dollars on medical care and quality improvement activities. If they fail to do so, they must provide rebates to their customers. The Medical Loss Ratio rule also improves value, increases transparency and accountability, and promotes competition among insurers. In 2012, 77.8 million consumers saved an estimated $3.4 billion up front on their premiums as more insurance companies operated more efficiently and spent less on overhead. And this year, 8.5 million consumers can expect a total of $500 million in rebates, with an average rebate of around $100 per family nationwide from insurance companies that did not meet the 80/20 standard in 2012. This is in addition to the $1.1 billion in rebates based on 2011 premiums, which benefited approximately 13 million Americans.[24]

Looking Ahead to 2014

We are proud of the accomplishments of the last three years, and we look forward to even more promising reforms of the Affordable Care Act that are set to start in 2014. Soon, a variety of consumer protections will take effect that will further strengthen the Health Insurance Marketplace, ending many of the insurance industry practices that make health care coverage too expensive or unavailable for many consumers.

In 2014, new rules will help make health insurance more affordable for more Americans.[25] Most health insurance companies will be prohibited from charging higher premiums to applicants because of their current or past health problems. Most insurance companies will no longer be able to charge women more than men based solely on their gender. Most insurers will be limited in how much more they can charge older Americans than young Americans, so insurance becomes more affordable for most Americans.

In addition to making coverage more affordable, beginning in 2014, new protections will help Americans of all ages maintain health insurance coverage, regardless of their health status. With

[24] http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2012-medical-loss-ratio-report.pdf

[25] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

limited exceptions, all non-grandfathered plans and policies in the individual and group markets will be required to enroll individuals, regardless of health status, age, gender, or other factors and will be prohibited from refusing to renew coverage because an individual or employee becomes sick. Plans will also be prohibited from putting annual dollar limits on benefits.

Soon, consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them. All non-grandfathered plans in the individual and small group markets will cover essential health benefits,[26] which include items and services in ten statutory benefit categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits will be equal in scope to a typical employer health plan. To this end, the essential health benefits will be defined in each state by reference to a benchmark plan.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider participation, and other factors, will help consumers make more informed decisions.

Insurance market reforms will also help large employers. Already, employers are reporting slower growth in health insurance premiums.[27] The Congressional Budget Office analyzed the net impact on premiums by market and found that for the large group employer market, the Affordable Care Act will result in a 0 to 3 percent premium reduction.[28] Employers (and their premium-paying employees) may also accrue additional gains as uncompensated care decreases and population health improves. We are also observing important signals that payment and

[26] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm
[27] Employer Health Benefits 2012 Annual Survey: http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf
[28] http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf

delivery system reforms are having an impact, including a decrease in the rate of patients returning to the hospital after being discharged and growing numbers of physicians and other providers participating in new payment initiatives that reward higher-quality and lower-cost care. By combining insurance market reforms, new efficiencies created by the Marketplaces, and programs such as reinsurance that will help stabilize premiums in the new Marketplaces, the Affordable Care Act reduces uncompensated care, increases competition among health insurance issuers, and reduces the hidden cost of uncompensated care for all premium payers.

Conclusion

By making coverage more affordable, improving the value of insurance coverage, and protecting consumers from the worst health insurance industry abuses, CMS is paving the way for a fairer, more transparent, more accessible health system. Over the last three and a half years, CMS and our Federal partners have been hard at work drafting policy, implementing consumer protections, working with stakeholders, and building IT systems that will enable Americans to shop and apply for insurance coverage starting just two months from now.

I appreciate this Committee's ongoing interest in our efforts and the opportunities you have given CMS to keep you appraised of our progress. It is my strong hope that we can work together to help provide the American people with the information they need about this important law. As the Administrator of CMS, I want to assure you that we stand ready to work with you and your constituents to answer questions or concerns as they arise, and are always eager to work with you on constructive suggestions to improve any CMS programs. Thank you for the opportunity to discuss CMS' important work to improve access to affordable health coverage for all Americans.

Mrs. BLACKBURN. And thank you, Ms. Tavenner. We appreciate that.

We will begin our questions, and I will begin by yielding myself 5 minutes.

And I want to start by talking with you about fairness, which is what I hear from my constituents. At this point, what they are doing is coming in to our meetings with papers in hand, and they can actually document the higher premiums, the disruptions in their existing coverage, and show me where it is due to the Affordable Care Act, or Obamacare. And while they are looking, many of them are looking for some reprieve from the taxes, the penalties, and the increased costs, you and your employees at CMS are fully protected, and you are eligible to keep the insurance coverage that you have, which you have taxpayer dollars that are paying for that insurance.

So I want to ask you this: If you are able, are you willing to enroll yourself in an exchange plan come October 1?

Ms. TAVENNER. If I were eligible for an exchange plan, I would be happy to enroll in an exchange plan.

Mrs. BLACKBURN. Should CMS employees, who are all responsible for implementing this law, be required to enroll in the same plans that Americans are being forced to enroll in, in these exchanges?

Ms. TAVENNER. Chairman Blackburn, I would say that if Congress decides that the employees of CMS should be enrolled in exchanges that the CMS employees would support that.

Mrs. BLACKBURN. Would you support a bill to that effect for you and all CMS employees?

Ms. TAVENNER. I would be happy to work with you on the development of a bill, and we can discuss that.

Mrs. BLACKBURN. Do you think all government employees, whether they are at Treasury, HHS, Labor, OPM, White House, that they should be subject to the same plans and premiums that our constituents are having to face?

Ms. TAVENNER. Well, I will remind you that if you look at the Affordable Care Act, if you remember, there is a large number of your constituents——

Mrs. BLACKBURN. We remember well.

Ms. TAVENNER [continuing]. That are not subject to the Affordable Care Act. Remember——

Mrs. BLACKBURN. That was not my question. And would you support having all these government officials having to enroll in an exchange plan, everybody involved in implementing this?

Ms. TAVENNER. To the extent that if you look at the exchanges, exchanges offer full coverage at reasonable prices, we are promoting competition, we are promoting transparency——

Mrs. BLACKBURN. We are in the Dingell room, so I am going to ask a Dingell question: Yes or no, would you support it?

Ms. TAVENNER. Yes, I would support it.

Mrs. BLACKBURN. OK. Thank you.

CMS has awarded Equifax a contract to conduct income verification of potential applicants seeking an exchange subsidy. So what is the estimated percentage of potential applications where

income data can actually be verified by Equifax, given the volume of data that it currently controls.

Ms. TAVENNER. I think there is a lot of confusion about income verification, so I would like to spend a couple of moments talking about that from the standpoint of the Federal exchange.

If you look at what happens when an individual fills out an application, and they record their income, there is a check, a 100 percent check against IRS. There is also a 100 percent check against Equifax. If those two, obviously, work, match, the individual proceeds. If there is a discrepancy, then we begin an intervention where individuals bring in pay stubs——

Mrs. BLACKBURN. Let me ask you this, then. Are you all going to have other contractors that are there to assist in verification of potential enrollees? And I am asking you this because the self-attestation provisions are of tremendous concern to us, especially to me. And you are familiar with TennCare and what happened there with self-attestation and Governor Bredesen's efforts to go pull all of these individuals off that program. So, you know, tell me how you are planning to handle that.

Ms. TAVENNER. We will do a 100 percent review of self-attestation.

Mrs. BLACKBURN. Immediately?

Ms. TAVENNER. Immediately.

Mrs. BLACKBURN. OK.

Ms. TAVENNER. Now, individuals—when I say "immediately," it obviously is a process where individuals bring in pay stubs, this sort of information, so that we work with an enrollment and eligibility worker. In the meantime, those individuals are——

Mrs. BLACKBURN. So 100 percent review means of all of their self-declarations, you are going to go back through every bit of that.

Ms. TAVENNER. That is correct.

Mrs. BLACKBURN. By when? If not immediately, by when?

Ms. TAVENNER. So if you will remember, what we have in regulation is they have—if an individual attests to their income, we enroll them for what they are eligible for. We have up to 90 days to reconcile that.

Mrs. BLACKBURN. So you foresee having all of this completed on each enrollee within 90 days?

Ms. TAVENNER. Absolutely.

Mrs. BLACKBURN. And if someone is committing fraud, how quickly will you remove them?

Ms. TAVENNER. If someone is incorrect, right, as soon as we find out that there is a problem, if they are not eligible for tax credits, they would be removed immediately.

Mrs. BLACKBURN. My time has expired. At this time I yield 5 minutes to Mr. Waxman.

Mr. WAXMAN. Thank you, Madam Chair.

Ms. Tavenner, you were asked is this fair that your employees aren't going to go into the exchange. Well, most people who are working in this country are not going to go to the exchange because they have their insurance through their jobs. Are they going to be required to go to the exchange and drop the insurance they already have?

Ms. TAVENNER. Absolutely not.

Mr. WAXMAN. So if employers offer insurance to their employees, that is not going to be affected. What we have tried to do is to give access to health insurance for those people who don't have coverage. Isn't that right? Isn't that what the exchanges and the bill is all about?

Ms. TAVENNER. That is absolutely correct.

Mr. WAXMAN. So it just seems to me so bizarre to hear arguments, well, are you going to go to the exchange? If you didn't have insurance, you would be delighted to be able to go and buy health insurance. If people lose their jobs, and we have seen a lot of people lose their jobs in the last couple of years, they usually lose their health insurance. Now, there is a thing called COBRA that allows them to pay the full cost, both the employer side and the employee side to keep that insurance. They won't have to do that anymore, they will be able to go to the exchange and choose between different private insurance plans that will be affordable to them. Isn't that correct?

Ms. TAVENNER. That is correct.

Mr. WAXMAN. So I just find it amazing, this attack all the time by the Republicans on the law that is going to help so many tens of millions of people get insurance. The whole insurance system of the country is not going to be transformed overnight. We are going to keep Medicare for people who are on Medicare. People who have insurance with their employers, they are going to keep it. And we hope small businesses will cover more of their employees because we are giving them tax breaks. But if small businesses don't cover their employees, they will be able to go to the exchange. Either the employees or the employers will be able to go to the exchange.

When you have an exchange, you are pooling people together so they have the advantages of the big employers in getting better insurance at a lower cost. Otherwise, if it is a small business or a small group or an individual, right now, if you are an individual, you have got no standing because these insurance companies don't want to insure you if you have a preexisting condition. But when you are in the pool with everybody else, they spread the cost. Isn't that the philosophy behind this law?

Ms. TAVENNER. That is absolutely correct. And that is the point I was trying to make with Congresswoman Blackburn. If I could not get insurance today, I would be very happy to have the exchange available. These are good plans at good prices.

Mr. WAXMAN. Absolutely.

Now, we hear a lot about rate shock, people are being scared, especially by Republicans and the right-wingers who want to scare people about the act itself and what it is going to mean to them. Even Chairwoman Blackburn alluded to all the increasing costs. And we hear about these predictions of major increases in costs, rate shock. They are not correct, are they?

Ms. TAVENNER. What we have seen to date, and what has been released, and I mentioned that in my opening statement, is we are actually seeing a reduction. And as we mentioned, it is actually coming in around 18 percent below CBO estimates. So we are very pleased. We are in the process of finishing out the Federal exchange rates. They had till July 31st, States did. So we will be looking at States who are on the Federal exchange.

But from the State-based exchanges, it has been a very good news story, and we are very pleased. And I think it just speaks to what happens when you have competition and transparency in a marketplace, plus the, quite honestly, the number of insurance laws that we have been able to adjust in the last 3–1/2 years.

Mr. WAXMAN. That is interesting, because you believe that the costs are going down because of transparency and competition.

Ms. TAVENNER. I do.

Mr. WAXMAN. I believe that, too, in any kind of product. If you have got competition, you are going to look at what is the best product and at the best price. And when these companies are competing for my business, they are going to want to hold down their costs. The benefits will all be the same, because the essential core benefits will be the same in every plan offered on the exchange. Isn't that correct?

Ms. TAVENNER. That is correct. And also a reminder that the things that we have done with MLR and other rules have not only had a benefit on small businesses and individuals, when I talk with large employers, and what we are seeing in large employers is they are reaping some of those rewards as well. Their average increase is around 3 percent. And while we don't want any increase, obviously, 3 percent is a lot better trend than we were seeing in the past.

Mr. WAXMAN. Most people don't have a choice of their health insurance, they are lucky if they get any health insurance at all. There is no competition, so they got to pay the price, whatever it is. If they can't afford it, they can't get it in this country. It seems to me that the attack is to keep things from being transparent and to prevent competition and help the consumers. That sure helps the insurance companies a lot.

Thank you, Madam Chair.

Mrs. BLACKBURN. Gentleman's time has expired. I recognize Mr. Barton for 5 minutes.

Mr. BARTON. Wow. OK. I was thinking I was later in the queue. But I am ready to go.

In my opening statement, I quoted from the Ennis Daily News of July the 23rd that the city of Ennis' increase in their plan that they provide to their employees was going up double, and that the monthly cost was about $50,000 a month for the city. The deductible was going up, the deductible was tripled, the city said that this was its largest increase in any budget item in the city budget. What is your response to that?

Ms. TAVENNER. My response to that would be I would want to take a look at that article, and I am happy to sit down with you.

Mr. BARTON. All right. Well, that is easy. We will make that happen. But I listened with interest to Ranking Member Waxman's questions. And he and I are apparently living in parallel universes because when I go to my town halls or when I am out in my district, I don't have anybody coming to me saying that they can't wait for the Affordable Care Act to be implemented and they are waiting for this great day when they can get all these benefits. I hear just the opposite. I hear small businessmen saying that they are not going to be able to provide the coverage. And I hear, like, the city employees of the town that I live in complaining that their pre-

miums are going up and their benefits are going down. And now we have you come and say that even though we are going to allow income verifiability based on self-attestation, we are going to then verify 100 percent of the self-attestations. Well, that doesn't make sense to me either.

Do you have data on 100 percent of the American population to verify the income levels? I was told that that was not available, which was why you were not going to use it.

Ms. TAVENNER. I will try to answer all of those questions, but let me start with the income verification, because I think there has been a lot of confusion out there on income verification. A reminder that when an individual records their income, it is first checked with IRS, based on the 2012 tax returns. If there is a match there and they are eligible, obviously, there is no need for—obviously, you are obviously signing, you are telling the truth. But we are able to check it. There is a second check through Equifax. OK? It is only when those two do not match that you have to go further and ask individuals for pay stubs or other information. And that is where I am saying we will do 100 percent proofing.

Mr. BARTON. All right. Well, the staff——

Ms. TAVENNER. It is a subset of the whole population, obviously.

Mr. BARTON. Well, I hope you are right. I mean——

Ms. TAVENNER. Well, I know I am right.

Mr. BARTON. I voted against this every time I could. But I do hope for the people's sake if we are going to implement it that you are right. Now I want to ask a specific question——

Ms. TAVENNER. Let me go back to answer your question about businesses. Just a reminder to individuals that if you are a small business, you are exempt from the requirement.

Mr. BARTON. If you have less than 50 employees or your average worker works less than 30 hours a week.

Ms. TAVENNER. Well, if you have less than 50 employees, you are exempt from having a requirement for coverage. Now, we hope that individuals will do that coverage because, obviously, we want more people covered, and that is the reason for the tax incentives and others.

For large employers, here is what I am hearing from individuals. When I start talking to them about their average cost increases, they are seeing very low cost increases in terms of premium. That doesn't mean that some employers aren't increasing their deductibles or copay, which is a business decision separate from the Affordable Care Act.

And the last thing I will tell you is if I ever lead—I have been in Texas, I have been in Florida, Louisiana, Georgia, Virginia, I can go on and on—if I ever lead with the Affordable Care Act, individuals are often confused about what I am saying. But if I lead with something that is like this, if you have had a preexisting condition and you can't get insurance or your insurance is $1,500 a month and you can't afford it, effective January 1 that doesn't exist any more, and here is why. If your child is being covered to age 26 and you are happy about it but you didn't understand why, here is why. So if you start——

Mr. BARTON. The only group that I think does benefit from the Affordable Care Act——

Ms. TAVENNER. Absolutely.

Mr. BARTON [continuing]. Are people that did not have and could not get coverage before. That 1 percent of the population does benefit if the coverage is available.

Ms. TAVENNER. Well, it is a lot more than 1 percent, but they do benefit.

Mrs. BLACKBURN. The gentleman's time has expired.

At this time I recognize the gentleman from Michigan, Mr. Dingell, for 5 minutes.

Mr. DINGELL. Madam Chairman, I thank you for your courtesy. I thank you for holding this hearing.

And thank you, Madam Administrator, for being here today.

We are 60 days away from the open enrollment period, which begins October 1. We are finally at the cusp of implementing reforms that are going to see to it that quality health care is a right and not a privilege. And now that we are close to full implementation of the law, we are going to have to guard against those who want this legislation to fail. This would be a dreadful, shortsighted policy which would hurt the country very badly.

My questions today, Madam Administrator, will focus on the benefits that we have already seen from the Affordable Care Act and what we may expect in the forthcoming months. Please answer these questions yes or no.

Will the new health insurance marketplaces be up and running for open enrollment as scheduled 60 days from now?.

Ms. TAVENNER. Yes, sir. Yes.

Mr. DINGELL. I would like you to give us a brief monograph on how the different States are going to be doing, because some will come in, some will not, some are going to partner. So if you could submit that to us for the record.

Ms. TAVENNER. Yes, sir.

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. Now, just this month the Department of Treasury announced that employer responsibility provisions of ACA were delayed for 1 year. Does this decision impact the implementation of the timetable for the remainder of ACA? Yes or no?

Ms. TAVENNER. No.

Mr. DINGELL. Would you like to submit a monograph, a brief paragraph explaining that, if you please.

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. Next question. One claim I have heard recently is that the employer delay will limit the ability of government to verify the incomes of applicants for purposes of determining the eligibility for subsidies. Will the marketplaces have income verification measures in place during 2014? Yes or no?

Ms. TAVENNER. Yes.

Mr. DINGELL. Now, Madam Administrator, in your testimony you note that between 1999 and 2012 the cost of coverage for an average family rose by 172 percent. Is that correct?

Ms. TAVENNER. Yes.

Mr. DINGELL. Madam Administrator, when the marketplaces are up and running, we hope that consumers will have a greater choice among health plans than they currently have in the individual market. Is that a real expectation?

Ms. TAVENNER. Yes.

Mr. DINGELL. Madam Administrator, consumers across the country will reap the benefits of increased competition through lower rates. We have already seen extraordinary results in States such as California, Oregon, Washington, and Vermont. Most significantly, in New York rates will go down by an average of 50 percent. Could you submit us a brief monograph on that particular point.

Ms. TAVENNER. Yes.

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. Administrator Tavenner, do you believe that increased competition amongst insurance companies is in any way responsible for the lower rates we have seen in these States? Yes or no?

Ms. TAVENNER. Yes.

Mr. DINGELL. Another provision in ACA that has helped lower rates is the rate review provision. Administrator Tavenner, in your testimony you indicate that Americans have saved over $1 billion in health insurance premiums thanks to this provision. Is that correct?

Ms. TAVENNER. Yes.

Mr. DINGELL. Furthermore, you also discuss how the average premium increase for all rates in 2012 was 30 percent below what it was in 2010. Is that correct?

Ms. TAVENNER. Yes.

Mr. DINGELL. Would you submit a brief comment on that answer and also on the answer to the previous question?

Ms. TAVENNER. Yes, sir.

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. Do you believe the trend will continue into the future? Yes or no?

Ms. TAVENNER. Yes.

Mr. DINGELL. Could you give us a brief statement as to why that might be so?

[The information appears at the conclusion of the hearing.]

Mr. DINGELL. Now that we are on the precipice of implementing this landmark law to its fullest extent and the Affordable Care Act is the law of the land, I believe we should all accept this fact and work together to ensure implementation goes smoothly as possible rather than rooting for the law to fail. I know that that is what the American people want of us, and it is my hope that we will be doing so.

Madam Chairman, I thank you for holding this hearing.

Madam Administrator, I thank you for your presence.

I yield back the 17 seconds remaining.

Mrs. BLACKBURN. The gentleman yields back.

At this time Mr. Shimkus, 5 minutes.

Mr. SHIMKUS. Thank you, Madam Chairman.

Let me first make a couple comments. I would be much more willing to be lectured by Norman Ornstein if he had placed his name on a ballot, ran for office, had been elected, and had to represent a constituency, than just another DC pundit who can throw accusations at if we are doing our job or not. So I just put that on the record.

Second thing is, for Diana, who is a great friend of mine, I would beg the question with your premise of how actively my friends on your side actively promoted Medicare D. I know I did. And I think if we could go back through the record of people who had town hall meetings and actually tried to enroll people in Medicare D, I think we could get a better idea than just making a statement.

I will say, though, because I am struggling with that issue of how do I get involved in this role and working with my State and its exchange, the problem is we have had three briefings so far and each briefing is different, and we don't have the information yet. And that is the State of Illinois.

Ms. DEGETTE. Will the gentleman yield?

Mr. SHIMKUS. I would.

Ms. DEGETTE. I would be happy to sit down, Mr. Shimkus, with you or anybody else on your side of the aisle and talk to you about what I have been doing in my district meetings——

Mr. SHIMKUS. No, and I don't doubt that. I am just saying to make a claim of Medicare D and how much you all were out there pushing it, I am questioning——

Ms. DEGETTE. I will tell you what you I did about that——

Mr. SHIMKUS [continuing]. The credibility of that.

Ms. DEGETTE. Be happy to.

Mr. SHIMKUS. Our folks in the media can do due diligence and really decide if they want to research that or not. I would question that.

Now, Marilyn, it is great to see you. She has been in my district before. Great credibility. Lot of support on both sides of the aisle from the Senate. So thank you for being here, and I know you have got a tough job on your hands.

I do want to refer two quick questions. One deals with the testimony on how you used the State of New York and talked about the premium issue. But didn't New York already require health insurers to issue coverage to all applicants, otherwise known as guaranteed issue?

Ms. TAVENNER. They did.

Mr. SHIMKUS. And did not New York already restrict rating and underwriting, otherwise known as community rating?

Ms. TAVENNER. I believe that is correct.

Mr. SHIMKUS. So part of the debate on this, and it is going to follow up to my next question, is, they are already a high State insurer, probably the fourth highest in the country. So they are already doing a lot of stuff that this law is forcing them to do. So you would expect that their rates would not be as high because they are already doing some of these new adds, versus a State like Illinois.

And our issue is not this coverage, our concern is people who have insurance are going to lose their insurance. That is our debate. People who have employer-sponsored health care will lose their health care, will be forced into an exchange in which they are going to pay 30 or 40 percent more.

And I am not doing an anecdotal story, I am just going to read a letter. I read this on the floor of the House yesterday during a 1-minute speech. And it is from a small businessman from Hamel, Illinois, which is in my district. And he says, "Last week, I was ad-

vised by my insurance agent that Blue Cross Blue Shield of Illinois is increasing my rates by more than 38 percent. I have to release one employee and have advised all remaining employees that their increase in health insurance premiums will be passed on to them. I was proudly able to pay 100 percent of the employees' healthcare coverage, but after two consecutive 20 percent increases in the last 2 years, and the latest 40 percent increase, simple business logic requires that I pass on this increase or simply go out of business. My employees will have less to take home—take-home pay under Obamacare."

And here is the question. I am going to ask it because he is asking us: "Does anyone in Congress realize that under this still uncertain program it is more logical for me to shut down my business and take subsidies on one of the exchanges than to remain open?" Do you all understand that this is what small business is dealing with?

Ms. TAVENNER. Congressman Shimkus, you know I have great respect for you, and I enjoyed being in your district as well. And I would be happy to sit down with you and go through this one because I am interested to see how the rate review process worked in this particular——

Mr. WAXMAN. Ms. Tavenner, would you pull the mike closer?

Ms. TAVENNER. I am sorry. I was saying that I would be happy to sit down and work with the Congressman on this issue, because obviously we now have rate review available in all States, so I am curious to see the process that went into that. But, obviously, if they have had years of 20 and 30 percent increases, this was prior to any influence of the Affordable Care Act.

Mr. SHIMKUS. And this one is 40 percent. The 40 percent is the straw that broke the camel's back, at least for this guy.

Ms. TAVENNER. Right. And this is the very issue that we are trying to address. And so I am happy to sit down and work with you.

Mr. SHIMKUS. Well, I would just say the debate really is we are afraid premiums go up, jobs get lost, more people go onto the exchange and can't afford the exchange amount which they had when they had employer-sponsored health care. That is really the difference in this debate.

Thank you, Madam Chair, and I yield back the balance of my time.

Mrs. BLACKBURN. Gentleman's time has expired.

Mr. Rush for 5 minutes.

Mr. RUSH. I thank you, Mr. Chairman.

Ms. Tavenner, I want to extend a warm welcome to you for your appearance before the committee today. And I also want to thank you for sending your staff to assist me and my staff with the Affordable Care Act town hall meetings and other events in my district. My constituents were happy to have them, learned a lot from them, and are looking forward to having more interactions with your excellent staff.

I want to ask you about the administration's decision to delay the employer mandate until January 1, 2015. There has been a lot of rhetoric from my Republican colleagues, a lot of hot air about how this decision is going to derail implementation of the ACA or is somehow an indication that the law is unworkable.

CMS is charged, Ms. Tavenner, with implementing four elements of the law. These include health insurance marketplaces, which will make sure every American has access to quality affordable coverage even if they have a preexisting condition. The 80/20 rule, which stops insurers from spending 25, 30, or even 40 percent of enrollees' premiums on profits and overhead and make them spend more on actual health care. And then there are the insurance market reforms, such as the end of lifetime and annual limits on coverage, and the requirement that insurance cover preventive care with no cost sharing. All of these four reforms put patients and their doctors and not the insurance company in charge of basic healthcare decisions.

Madam Administrator, what does Treasury's recent decision mean for the core elements of the law that CMS is charged with implementing? And people who do not receive healthcare coverage from their employers next year will in general be able to afford affordable, high quality coverage through the State or Federal marketplaces. I think that is correct. Would you answer those questions?

Ms. TAVENNER. Yes, sir. The delay of the employer mandate does not have any impact on CMS' implementation. Just as a reminder, the delay of the employer mandate was a decision to try to work with business. And I have heard this morning that we need to work with business and help them. And a reminder also that 96 percent of large employers currently have coverage.

So this employer mandate was also a very small subset. And the decision to delay for 1 year was to try to help not increase regulatory burden on employers as they walk through this process, and it has no impact on our implementation.

Mr. RUSH. So it is safe to say that delaying the employer mandate for a year is not going to derail the law, and that the core elements are going into effect as planned.

Ms. TAVENNER. Yes, sir.

Mr. RUSH. Well, it seems to me exceedingly wrong and backwards and ill informed by my Republican colleagues to try to use this relatively minor transitional relief to try to sow doubt and confusion about whether this law is going into effect. It is really cold-blooded, cold-hearted, and callous, and they should be ashamed of themselves.

I yield back the balance of my time.

Mrs. BLACKBURN. Gentleman yields back.

Mr. Pitts for 5 minutes.

Mr. PITTS. Thank you, Madam Chair.

Ms. Tavenner, on April the 10th, 2013, the Office of Management and Budget released its sequestration preview report for fiscal year 2014. In this report, OMB confirmed the cost-sharing subsidy program in the ACA is subject to sequester to 7.2 percent reduction, a reduction of $4 billion. Has CMS communicated to officials operating an exchange, both Federal and State, how this sequester will be applied?

Ms. TAVENNER. We have not. We are still working with OMB.

Mr. PITTS. Will the navigators and other assistance personnel be expected to properly explain to enrollees the new cost-sharing levels under sequester?

Ms. TAVENNER. That is currently under review with OMB, so I would have to get back to you on that.

Mr. PITTS. Well, doesn't this mean applicants may not be aware of their financial liability when signing up for an exchange plan?

Ms. TAVENNER. Once again, I will follow up with you after I have had discussion with OMB.

Mr. PITTS. All right. Well, given that the Department has had significant time to prepare for reductions in cost-sharing subsidies as part of the sequester, is this information available to the public?

Ms. TAVENNER. Congressman Pitts, I will have to work with OMB and get back with you on that.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Can you commit to providing detailed information regarding the implementation of the cost-sharing subsidy program?

Ms. TAVENNER. Yes, sir. I can commit to providing you information. Of course it is our strong preference that the issue of sequestration go away entirely.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Will this information be available before open enrollment, which starts on October 1, 2013?

Ms. TAVENNER. Yes, sir.

Mr. PITTS. I don't, you know, mean to ask the same question again, but are you actually testifying in front of this committee that agencies will likely be giving exchange subsidy applicants incomplete information about their financial liability? Telling my constituents to talk to OMB is really not an answer.

Ms. TAVENNER. That is not what I am saying. I am saying that I will follow up with OMB and get back to you with an answer.

Mr. PITTS. Another question. Has CMS conducted live, end-to-end testing involving all parties responsible for implementation, including the Departments of Homeland Security, the Social Security Administration, the Treasury Department, HHS, OPM, State Medicaid agencies, State exchanges, and associated contractors?

Ms. TAVENNER. So that is several questions, so let me try to answer them one by one. We started testing in October of last year, October of 2012. And so as we test we move from basic to more complex scenarios. So we will finish all end-to-end testing by the end of August.

So when you talk about systems, let me start with insurers. We have accepted their QHP submissions for more than 120 issuers. We began enrollment testing those scenarios in July. They will be complete by the end of August. And then obviously payment testing occurs between September and December because, if you remember, payments do not go out until January.

Mr. PITTS. I only have so much time. I only have a minute left. Have you had one live test with all the agencies?

Ms. TAVENNER. With all the Federal agencies? Absolutely.

Mr. PITTS. Yes. And what vulnerabilities and challenges has such testing revealed?

Ms. TAVENNER. I am happy to give you a more detailed explanation from our IT folks.

[The information appears at the conclusion of the hearing.]

Ms. TAVENNER. But as we have identified any vulnerabilities we correct them. And so right now we are in good shape.

Mr. PITTS. OK. Do the contractors who HHS is paying to build these exchanges have certain targets or milestones that they have to meet?

Ms. TAVENNER. Absolutely.

Mr. PITTS. Can you tell us today that every contractor has met these targets and is on time?

Ms. TAVENNER. Yes, sir, I can.

Mr. PITTS. Will HHS provide any reports, audits, or work plans to the committee to show the contractors' work?

Ms. TAVENNER. We will certainly provide anything that we can that is publicly available. And I am happy to have people come sit down with you and walk you through our testing.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Have any of the contractors asked for delays of their contract deadlines or work plans?

Ms. TAVENNER. No, sir.

Mr. PITTS. My time has expired. Thank you, Madam Chair.

Mrs. BLACKBURN. Gentleman yields back.

Ms. Eshoo, 5 minutes.

Ms. ESHOO. Madam Administrator, welcome. And thank you for the work that you are doing on what is truly historic. It is a heavy lift because it has many working parts, 50 States, hundreds of millions of people in our country. But I think that the confidence with which you have approached this and the experience that you bring to it will only enhance the pulse check on the Affordable Care Act.

Now, my colleague from Illinois intimated that Norman Ornstein really doesn't have any skin in this game because he is a scholar and he is not elected. Well, you know what? Our constituents are not elected either. Scholars aren't elected. But you know what? They all count in our country. So I think that Norman Ornstein and Thomas Mann are recognized as the two preeminent congressional scholars. Neither Republicans or Democrats do they claim. I don't know how they are registered, but I welcome what they write and how they think, and I think we can all draw something from it whether we agree or not. I didn't think I was going to get to Norm Ornstein this morning, but I can't help but jump in and say something about "just because they are not elected" that they don't count.

There is something extraordinary that is taking place: not only the implementation of the ACA, but the counterpush in the House of Representatives where for the 40th time—not 4th time—but 40th time that the Republicans are moving to repeal the law. I don't know, and maybe I will have to check with Norm Ornstein or the Librarian of Congress to see if there has ever been any such effort in the history of our country where something has been taken up 40 times.

I believe my friends on the other side of the aisle are on the wrong side of history.

Now, I think that what we need to examine is what people are now legally entitled to as a right, not only having been passed into law, but confirmed by the United States Supreme Court. But none of that seems to matter. For the 40th time they are going to move to repeal.

But I would like to examine this through the lens of constituents and the right that they have and the rights that my colleagues want to take away from them. These are very important things that my colleagues want to take away from them. They want to take away closing the prescription drug donut hole that was created through the program that they passed. They want to take away from children the ability for them to stay on their parents' insurance policy up to the age of 26. They want to take away from them what is now prohibited, and that is the lifetime limit caps on insurance policies.

How can anyone argue that lifetime limit caps were terrific? You are arguing to take that away from your constituents.

You want to take away preventive services from your constituents, like mammograms and colonoscopies. Don't you get those now? Doesn't your wife, your spouse enjoy that now? Why do you want to take that away from your constituents? Take away health care premiums that are truly spent on medical care instead of advertising, and the right to plain language explanations of a plan's benefits, and most of all take away the freedom by decimating the whole issue of preexisting conditions. That is taking away a lot of rights that the American people have today. And I think that is the lens in which to examine this.

I would just like to ask you, Madam Administrator, very quickly about the flexibility the States have. There has been an awful lot tossed around that States are going through hell, that people are being forced. Can you just spend a moment to explain the flexibility that States are being offered in this?

Ms. TAVENNER. Yes, and there obviously are various types of programs. Obviously, we have 17 State-based exchanges where they have tremendous flexibility. They are basically establishing their own programs, following the law, and then we have some oversight. The second one are we have created various types of partnerships to try to work with States, such as in Utah with the SHOP, where they wanted to be involved in SHOP.

We have created other partnerships where States wanted to keep their review of health plans or they wanted to do consumer outreach. We are currently working with Mississippi——

Mrs. BLACKBURN. Ms. Tavenner?

Ms. TAVENNER. Sorry?

Mrs. BLACKBURN. If you will submit for the record. We are a minute over time and we are trying to keep it to 5 minutes as a courtesy to all members.

Ms. TAVENNER. Right.

Mrs. BLACKBURN. Thank you, Ms. Eshoo.

At this time I yield to Mr. Terry, 5 minutes.

Mr. TERRY. Thank you, Madam Chair.

Appreciate you being here. And I am going to ask some questions about transparency and if information is being withheld from this committee regarding particularly data hubs.

So as I understand, HHS has contracted with a number of companies to help build different parts of what is known as the data hub. Is that correct?

Ms. TAVENNER. The data hub is actually a single contract.

Mr. TERRY. It is a single contract for the data hub?

Ms. TAVENNER. Yes.

Mr. TERRY. And is UnitedHealthcare Group, their subsidiary, QSSI, that contractor?

Ms. TAVENNER. That is correct. That is correct.

Mr. TERRY. Now, last month GAO issued a report stating that the exchanges are behind schedule. A number of news articles in the last month have talked about the expected glitches and the fact that the companies—or company—setting up these systems is racing to get it done in time.

This committee has asked UnitedHealthcare to provide us with a briefing on the status of the building of the data hub, and they have refused and told us to talk to HHS. So has HHS or you as under HHS told UnitedHealthcare not to talk to us?

Ms. TAVENNER. We have not. I have not. Speak for myself. I have not said that.

Mr. TERRY. Do you have any concerns about UnitedHealthcare/QSSI talking to our committee?

Ms. TAVENNER. We have frequently brought—usually we have——

Mr. TERRY. I am sorry, is that a yes or no? Do you have a problem with UnitedHealthcare talking to this committee?

Ms. TAVENNER. I do not have a problem with that. I was going to say we have done that in the past, and we have actually brought contractors with us to talk to committees.

Mr. TERRY. OK. Do you think it is a fair conclusion that when somebody refuses to talk to you that they are hiding something?

Ms. TAVENNER. I do not think that is a fair conclusion.

Mr. TERRY. You don't?

Ms. TAVENNER. No.

Mr. TERRY. You don't think that when somebody refuses to talk to you that there is a reason behind it?

Ms. TAVENNER. I think perhaps maybe they wanted to doublecheck with the person who is doing the contracting, but I think we can work this out.

Mr. TERRY. So when United refuses to talk to us, they are not trying to hide anything, they are just being a good company?

Ms. TAVENNER. They are a good company to work with.

Mr. TERRY. OK. So I will ask you then what they won't talk to us about: How much money has HHS paid UnitedHealthcare and QSSI to date?

Ms. TAVENNER. Through the QSSI contract, I think we have spent about $400 million to date on the building of the hub. But if you would let me, I will get you specifics. As you might imagine, both testing and our spending are dynamic, so I may have data that is a week or 2 old.

[The information appears at the conclusion of the hearing.]

Mr. TERRY. Is QSSI/UnitedHealthcare on schedule?

Ms. TAVENNER. Yes.

Mr. TERRY. Have they met each of their targets set by HHS for their work?

Ms. TAVENNER. That is something I am happy to review with you in detail. I don't want to speak to each and every target, but obviously we are on schedule for October.

Mr. TERRY. But you would have no problems with UnitedHealthcare talking to us about that as well?

Ms. TAVENNER. I would have no problem with that. We have done that in the past.

Mr. TERRY. Has UnitedHealthcare/QSSI begun to do test runs of the data hub?

Ms. TAVENNER. Yes, they have begun test runs.

Mr. TERRY. Have there been any glitches discovered?

Ms. TAVENNER. I would to have to go through the specifics of that. But of course we make modifications as we go. But if you are asking——

Mr. TERRY. That is the whole point of doing a test.

Ms. TAVENNER. Right. And the testing, we have made modifications and the system is working.

Mr. TERRY. Now, has UnitedHealthcare/QSSI tested the connections with the relevant agencies, such as Social Security Administration?

Ms. TAVENNER. Yes.

Mr. TERRY. Have they tested the connections with the Department of Homeland Security?

Ms. TAVENNER. Yes. And I am happy to get you a schedule of that testing.

Mr. TERRY. OK. And the same question with the Internal Revenue Service.

Ms. TAVENNER. Yes. And I am happy to get you a schedule of the testing of each of our Federal partners.

Mr. TERRY. Have they tested the connections with State Medicaid programs?

Ms. TAVENNER. Yes, that work is in progress.

Mr. TERRY. Good. Are there other contractors? Will you tell us what Equifax' and SERCOS's involvement is?

Ms. TAVENNER. Equifax' involvement is income verification. As I was discussing earlier, we have a contract with them so that when an individual completes an application and fills out their income, we check that against IRS records, as well as Equifax records, to verify accuracy. They have that contract.

Mr. TERRY. Thank you.

Mrs. BLACKBURN. The gentleman's time has expired.

Ms. DeGette, 5 minutes.

Ms. DEGETTE. Thank you very much, Madam Chair.

Ms. Tavenner, I want to add my thanks to you for coming to testify today. I have a couple of areas I want to explore with you. The first one is these data hubs that are going to be managed by HHS and that are going to provide access to information that is necessary to determine an individual's eligibility for certain ACA benefits.

Yesterday in the Denver Post, in part of what seems to be a national campaign on this issue, there was an op-ed that raised concerns about the privacy of data that is going to be provided to individuals who sign up for health insurance on the Federal marketplaces. And obviously, after the recent leaks on the NSA, we are all concerned about privacy. But the op-ed stated, in my opinion a little hysterically, quote, "The Federal data hub is a privacy dis-

aster waiting to happen, drawing from databases of seven different U.S. agencies, including the Department of Justice and IRS."

So I hope that you can help us address some of these concerns about data hubs.

First, Administrator Tavenner, very briefly, what are these data hubs?

Ms. TAVENNER. So there is a single data hub, and I think that is an important piece of information. It serves as a router. And it is important to note that the hub does not store any information. It routes information. Second point is there is no health information stored or scattered.

Ms. DEGETTE. So what type of information is involved with these data hubs?

Ms. TAVENNER. OK. What the data hub does is you fill out an application, then that automatically, for lack of a better word, pings Social Security, and so we verify that what you are entering as a Social Security number matches you as an individual. Then it also will ping Social Security for if you are eligible for other types of programs which would make you ineligible for tax credits. Then it will move, it moves through each of the systems that make sense, right, Homeland Security, you are verifying that person is a legal citizen, you are verifying if they are eligible for other programs such as TRICARE, et cetera. And so you are making sure that this individual is actually eligible for a tax credit. This is a routing of information, no storage in the hub——

Ms. DEGETTE. Right. So once the information has been checked against all those sources that you just talked about and confirmation has been forwarded back to the appropriate marketplace, what you are saying is this information is not stored. Is that right?

Ms. TAVENNER. It is not stored in the hub. When the individual actually completes an application, then we do store that application in the marketplace, which is a separate piece. So that if you are making an appeal or whatever, we are able to go back to your record. But again, we do not store health information.

Ms. DEGETTE. So the information that has been stored in the marketplace, who has access to that information?

Ms. TAVENNER. Individuals who have access to the marketplace are enrollment and eligibility workers that are either through the State-based exchange, they have their own enrollment and eligibility workers, or we have a single contract, which is the SIRCOS contract.

Ms. DEGETTE. And what are we going to do to make sure that those workers do not use that information inappropriately?

Ms. TAVENNER. There is a series. The history of CMS is we handle millions of records. So we have very tight security controls, the Privacy Act, we follow all the security requirements agreements.

Ms. DEGETTE. So let me just ask you, as Mr. Dingell would say, could you just provide us with a short written answer what the agency is doing to ensure consumers' privacy about this information?

Ms. TAVENNER. Yes. But it will be a lengthy answer because we have lots of security——

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. Lengthy is good in this situation. Thank you.

I have one last issue I want to talk to you about, because we keep hearing about people talking about again and again how health care reform is going to increase health care costs. So I am wondering if you can talk very briefly to us about recent trends in Medicare spending growth.

Ms. TAVENNER. Yes. We are very pleased with recent trends in Medicare spending growth. We have actually seen for 3 years in a row the lowest growth ever in Medicare spending, and we are very pleased with that.

We think it is a combination of things. Obviously, there are some payment reforms we have put in place. But we are most excited about our delivery system reforms, and we are excited about those because they are actually changing from paying for quantity to actually paying for outcomes. And we are taking this delivery system changes and we are spreading it across not only Medicare, but Medicaid, and we are working closely with the private industry to make sure this is an effort—we want to be agnostic to payer. What we are trying to do is actually change the system so that we have coordinated care at lower cost. And we are actually focused on the high costs, which are complicated care, complex, long-term chronic disease. So it is a combination of things.

Ms. DEGETTE. Thank you very much.

Thank you Madam Chair.

Mrs. BLACKBURN. Gentlelady yields back.

Dr. Murphy, 5 minutes.

Mr. MURPHY. Thank you Madam Chair.

First of all, to get on the record, I just want to make sure we are still working on this. Is it your and the administration's intention to respect and adhere to the Constitution's First Amendment freedom of religion in the implementation of this law with employers.

Ms. TAVENNER. Yes.

Mr. MURPHY. Thank you. Now I want to get at some other things here. I want to ask you a simple and direct question. Has the Affordable Care Act resulted in employers cutting workers' hours because of the mandate, yes or no?

Ms. TAVENNER. No.

Mr. MURPHY. OK. Well, let me tell you a story here. A gentleman contacted me who works two full-time jobs, one with a transformer manufacturer, another with a restaurant. He has a health insurance plan with the transformer manufacturer, but the restaurant says they have to cut his hours to part-time because otherwise they would have to provide him with health insurance. He asked the office, my office, if there was a form to fill out to prove the restaurant he has health insurance. So we called the Department of the Treasury asking them if there was anything they can do to assist him. Treasury officials we spoke to said that it is an issue between the gentleman and his employer, there is no way for the Federal Government to prove to the restaurant he has insurance with another employer and that they have no solution.

Now, is the answer the administration is giving to people acceptable under those circumstance, they have no way of working on such things to prove that they have insurance?

Ms. TAVENNER. I cannot speak to Treasury's answer, but I will tell you that when I——

Mr. MURPHY. Do you have any solution to that?

Ms. TAVENNER. Yes. When I am out in the marketplace I have actually met with small business, with large business. We are not seeing folks changing their hours. Yes, we hear anecdotal stories as well.

Mr. MURPHY. This goes back to the parallel universe situation. And when we had before my subcommittee, Oversight and Investigations, Mr. Mark Iwry, he was a senior adviser with the Department of Treasury, he had said that one of the issues of why they needed to delay the mandate for a year for employers was because employers were having a number of problems there. When asked specifically if he was hearing from individuals, it appeared that they did not have that, so I asked what his address was so people could let him know.

Now, I am hearing from you that you are not hearing from people either, which I think is a problem. So who can Americans write to, to get you the facts—because apparently you are not hearing them—that employers are cutting back hours and employees are losing hours? Should they just write to you care of CMS?

Ms. TAVENNER. They can certainly write to me, and many of them do. But I think——

Mr. MURPHY. But apparently you are not hearing——

Ms. TAVENNER. I am out actually in the markets talking to individuals.

Mr. MURPHY. I hear that, but the fact that you are saying that you are not hearing that anybody is losing hours is phenomenal, because this is where—look, we understand that this is the law. We are trying to get transparency. But when you and the administration hide things in a Fourth of July blog or in the middle of some other document, or one bill appears before us in committee and another one appears before us on the floor and waivers are granted to people, there is something wrong.

Now let me ask about this, too. Recently, some of the law's original supporters, labor unions, have claimed the law would substantially harm their current medical benefits despite many promises that if you like your coverage you can keep it. Are you having discussions with these unions about the impact of health care on their coverage?

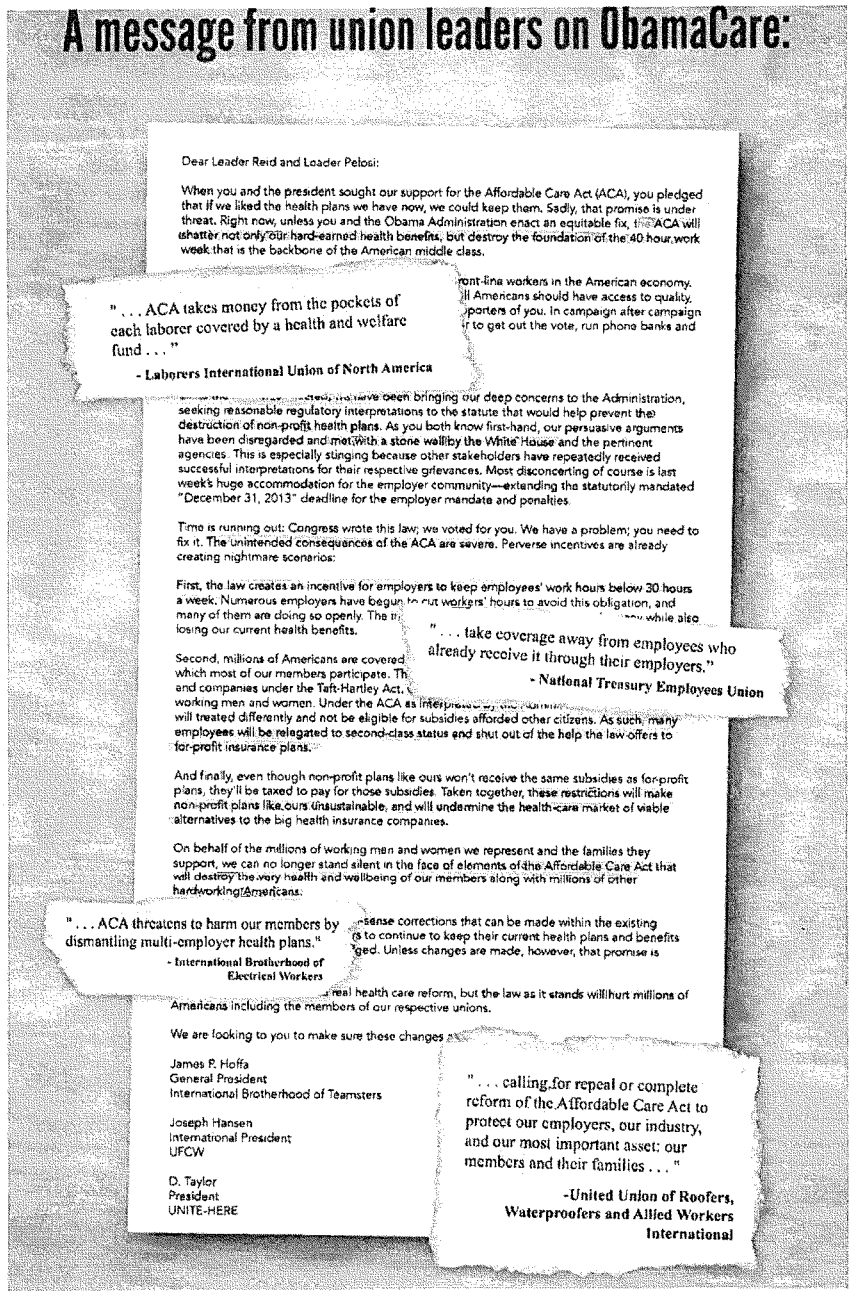
Ms. TAVENNER. Yes, we are certainly having discussions with unions.

Mr. MURPHY. Did you see the full page ad in today's Washington Post from the Teamsters, the International Brotherhood of Electrical Workers, the Laborers International, the Treasury Employees, the United Union of Roofers, Waterproofers and Allied Workers saying it threatens to harm their members, that it takes money from the pockets of each laborer covered by health and welfare fund, it takes coverage away from employees who already receive it through their employers? Have you seen this ad?

Ms. TAVENNER. I have not.

Mr. MURPHY. It is in today's paper. You might want to take a look at it.

[The information follows:]


A message from union leaders on ObamaCare:
Dear Leader Reid and Leader Pelosi:
When you and the president sought our support for the Affordable Care Act (ACA), you pledged that if we liked the health plans we have now, we could keep them. Sadly, that promise is under threat. Right now, unless you and the Obama Administration enact an equitable fix, the ACA will shatter not only our hard-earned health benefits, but destroy the foundation of the 40-hour work week that is the backbone of the American middle class.
". . . ACA takes money from the pockets of each laborer covered by a health and welfare fund . . . "
- Laborers International Union of North America
". . . take coverage away from employees who already receive it through their employers."
- National Treasury Employees Union
". . . ACA threatens to harm our members by dismantling multi-employer health plans."
- International Brotherhood of Electrical Workers
". . . calling for repeal or complete reform of the Affordable Care Act to protect our employers, our industry, and our most important asset: our members and their families . . . "
-United Union of Roofers, Waterproofers and Allied Workers International

Mr. MURPHY. This is no small concern. Now, you are saying that you haven't heard from people. It seems to me that these folks who represent thousands and thousands of workers are saying they are seeing some real problems here.

Ms. TAVENNER. I have actually said we have had ongoing meetings.

Mr. MURPHY. This is 26 million people. Now, that is more than significant. And you are saying you are not hearing from people that there is a problem?

Ms. TAVENNER. For the third time, I have said we have had ongoing discussions with the labor unions.

Mr. MURPHY. Are they telling you there are problems with people losing their jobs or losing coverage?

Ms. TAVENNER. We have heard their concerns and we are——

Mr. MURPHY. Are you hearing from them that there is problems with people losing their jobs or losing their coverage?

Ms. TAVENNER. I have not heard that specifically.

Mr. MURPHY. Whoa. Would you like to read today's paper? And this isn't the first time they have printed this in articles in Washington, DC.

So this is the parallel universe. Look, I understand this is the law, but our concern is that if you are all living in "Alice in Wonderland" you can't manage what you can't measure. You can't measure what you are not paying attention to. And although there are people on the other side of the aisle who are saying that we are not handling this the right way, this is our obligation to make sure that we are providing the kind of oversight to this.

And if you are not listening to the American people and not listening to labor unions, then some poor individual who contacts me that works at a restaurant and says, "I don't know what to do," I have no answer for him.

Thank you, Madam Chair.

Mrs. BLACKBURN. The gentleman yields back.

Ms. Matsui.

Ms. MATSUI. Thank you very much, Madam Chairman.

And welcome, Madam Administrator. We are so happy to have you here and glad that you are on board.

I just have a few questions here. You know, opponents of reform have spent a lot of energy trying to scare seniors into believing that they were losing Medicare benefits because of health reform. I would like to take this opportunity to correct this misinformation.

Administrator Tavenner, isn't it true that no senior will see their guaranteed Medicare benefits reduced, whether in private Medicare Advantage plan or traditional Medicare where seniors have free choice of doctors because of the Affordable Care Act?

Ms. TAVENNER. Yes.

Ms. MATSUI. Yes or no?

Ms. TAVENNER. Seniors continue to receive all of their benefits.

Ms. MATSUI. With the improvements in preventive benefits and prescription drug coverage, benefits actually improve for all Medicare beneficiaries, correct?

Ms. TAVENNER. Correct.

Ms. MATSUI. In fact, in your testimony, you stated over 6.6 million seniors have saved more than $7 billion on their prescription drugs as a result of the ACA. Is that correct?

Ms. TAVENNER. That is correct.

Ms. MATSUI. And almost 17 million Medicare beneficiaries have taken advantage of at least one free preventive service thus far in 2013, correct?

Ms. TAVENNER. Correct.

Ms. MATSUI. OK. Thank you very much. And I will make sure this summer that my constituents understand that.

Now, we all agree that eliminating waste, fraud, and abuse in Medicare and Medicaid should be a top priority as we seek to reduce spending. Roughly 10 percent of Medicare funding is lost to waste, fraud, and abuse each year.

Now, the Affordable Care Act takes important steps toward combating health care fraud, waste, and abuse, and over the last 3 years alone $10.7 billion has been returned to the Medicare Trust Fund thanks to the ACA's anti-fraud provisions. I understand that just last week CMS imposed a temporary moratorium on the enrollment of Medicare home health providers in specific areas of the country considered fraud hotspots.

Can you give us a sense of other successful examples of the instances where the ACA has enabled CMS to successfully combat waste, fraud, and abuse?

Ms. TAVENNER. Yes. Obviously the moratorium was an important step and the first time we have actually taken that action. And the other areas, we have moved to a lot more on the predictive modeling. Instead of paying the funding out and then having to go recover, we are trying to do more sophisticated analytics, and so we have seen recoveries increase year over year over year. But likewise there is still a fair amount of fraud out there, so we have close working relationships with the OIG and DOJ, and we have expanded what we are calling our HEAT Programs and our work in that area.

We also have a close partnership with the States, working with attorneys general, and we have recently created a public-private partnership to work with insurers directly. So we are trying to combat fraud from many different angles. And we appreciate the tools that were given to us in the Affordable Care Act and the increased penalties to allow us to put more pressure in that area.

Ms. MATSUI. Thank you very much.

Now, amid all the important growth to help enroll millions of Americans into Medicaid and new and improved private insurance options, we must not lose focus on one of the chief goals of health reform, transforming our current sick care system into a true health care system. As you know, a number of provisions in the Affordable Care Act were aimed squarely at promoting prevention, for example coverage for annual wellness visits for seniors in Medicare, access to recommended preventive services, no cost sharing for those in the new marketplace plans, and the creation of the historic Prevention and Public Health Fund.

To what extent is CMS overseeing implementation of these provisions and what progress can you report?

Ms. TAVENNER. As you mentioned earlier, and we sent reports out this week of the uptake in preventive services that we have seen in Medicare. We are also doing the same type of work in Medicaid, and the same type of cost sharing, lack of cost sharing, et cetera, is available on the exchanges. So there has been a big push toward prevention and a big piece of making prevention the first piece of the healthcare system and one that doesn't have copays or deductibles so we can encourage individuals to take advantage of the program.

It is also part of our regular ongoing marketing and educational information. And we will continue that as we open the exchanges.

Another point I will make is frequently we are so busy talking about the exchanges we forget to talk about the Innovation Center and the work that is going on there, which is also steeped in prevention, and working with States.

Ms. MATSUI. Well, thank you very much, and I look forward to continue to work with you.

Thank you. I yield back my time.

Mrs. BLACKBURN. The gentlelady yields back.

Dr. Burgess 5 minutes.

Mr. BURGESS. I thank the chairwoman.

First off, I would like to ask unanimous consent to put into the record a list of seven House-passed bills that President Obama has signed into law that repeal or defund parts of his healthcare law. And I would ask that be made part of the record.

Mrs. BLACKBURN. So ordered.

[The information follows:]

Seven House-Passed Bills President Obama Signed that Repeal or Defund Parts of His Health Care Law

Posted by Don Seymour
May 14, 2013
General

The House will vote on H.R. 45 this Thursday to fully repeal the president's health care law, which is driving up costs, jeopardizing seniors' access to care, and making it harder for small businesses to hire. While our goal is to repeal all of ObamaCare – and this will be the third time the Republican-led House has voted for full repeal since 2011 – we've already succeeded in repealing and defunding parts of it.

Here's a look at how seven bills* signed by President Obama helped dismantle provisions of his health care law to protect our economy and save taxpayers tens of billions of dollars:

- **H.R. 4: Repealed the small business paperwork ("1099") mandate**: The paperwork mandate was called "one of Washington's dumbest ideas" – it would have destroyed jobs and "hit start-ups hardest, not to mention farms, charities and churches." House Republicans kept their *Pledge to America* and repealed it. H.R. 4 also reduced exchange subsidy overpayments by $25 billion.
- **H.R. 1473: Cut $2.2 billion from a "stealth public plan" and froze the IRS budget**: H.R. 1473 undermined ObamaCare by cutting $2.2 billion from the "Consumer Operated and Oriented Plan" (CO-OP) program – a "stealth public plan." It saved $400 million by eliminating "Free Choice Vouchers," which *The Hill* warned "could lead young, healthy workers to opt out" of their employer plans, "driving up costs for everybody else." And it ensured the IRS wouldn't receive additional funding for new agents to enforce the president's health care law.
- **H.R. 674: Saved taxpayers $13 billion by adjusting eligibility for ObamaCare programs**: This bill not only repealed a devastating IRS withholding tax – it saved taxpayers $13 billion by changing how the eligibility for certain programs is calculated under ObamaCare. Without the change, a couple earning as much as much as $64,000 could still qualify for Medicaid.
- **H.R. 2055: Made more cuts to CO-OPs, IPAB, IRS**: This bill shaved another $400 million off the CO-OPs; cut another $305 million from the IRS to hamper its ability to enforce the law's tax hikes and mandates; and rescinded $10 million from the Independent Payment Advisory Board (IPAB) of bureaucrats, to which Republican leaders are declining to recommend appointments.
- **H.R. 3630: Slashed billions from ObamaCare slush funds**: Republicans fought for another $11.6 billion in savings, saving taxpayers $5 billion from the Prevention & Public Health slush fund, $2.5 billion from ObamaCare's "Louisiana Purchase," and more.
- **H.R. 4348: Saved another $670 million from the "Louisiana Purchase"**: This saved another $670 million by further adjusting a drafting error that made the "Louisiana Purchase" even costlier.

- **H.R. 8: Repealed the unsustainable CLASS program**: H.R. 8 saved $6.5 billion by repealing the Community Living Assistance Services and Supports (CLASS) program, an unsustainable entitlement program whose phony "savings" were used by Democrats to mask the true cost of ObamaCare. The former Democratic chairman of the Senate Budget Committee called CLASS "a Ponzi scheme of the first order, the kind of thing Bernie Madoff would be proud of." The bill also rescinded all unobligated CO-OP funds – another $2.3 billion savings for taxpayers.

Are these enough? Of course not – full repeal is needed to keep this law from doing more damage to our economy and jacking up costs on Americans. But Republicans have made some progress, and will keep working to scrap the law in its entirety so we can focus on patient-centered reforms that lower health care costs and protect jobs.

* *Information compiled by the Office of the Majority Whip Kevin McCarthy (R-CA)*

- See more at: http://www.speaker.gov/general/seven-house-passed-bills-president-obama-signed-repeal-or-defund-parts-his-health-care-law#sthash.QdG4AJzg.dpuf

Mr. BURGESS. Madam Administrator, let me just ask you, and this is a quick one, April 13th, 31 members of this committee from both sides of the dais sent you a letter on the issue of the average sales price Part B drugs in Medicare as they were affected by the sequester. Many of us think you have done the math wrong. You have sent us a reply that was actually a nonresponse. So we sent you another letter asking for an actual response. That was over a month ago. Can we expect a response to the second letter?

Ms. TAVENNER. Absolutely.

Mr. BURGESS. Very well.

The issue of delaying the employer mandate, now, you testified before another committee that that was something you learned about late in June. Is that correct?

Ms. TAVENNER. June 25th.

Mr. BURGESS. Well, who made the decision to do that?

Ms. TAVENNER. I did not answer who made the decision. Obviously it falls under——

Mr. BURGESS. Yes, you did. Who told you that it was going to happen?

Ms. TAVENNER. I actually heard about it from my chief of staff on a phone call.

Mr. BURGESS. Well, I would appreciate you getting back to us with the information of who phoned your chief of staff.

At any point did Valerie Jarrett interact with your office and say, "This is what we are going to do"?

Ms. TAVENNER. Valerie Jarrett did not interact with me.

Mr. BURGESS. Did you think it odd that it was a blog post on Valerie Jarrett's blog that informed the country of the delay of the employer mandate?

Ms. TAVENNER. I don't know that I would think it odd.

Mr. BURGESS. Well, the rest of the country thought it was odd. You know, there are still a lot of unanswered questions there as to who is actually pulling or who is actually in charge here. I think you are supposed to be in charge, so I think you would have to be integrally involved with that decision, and yet I get the impression from you that you were kind of an innocent bystander while something came out of the West Wing of the White House. And that makes me uncomfortable because we had Mr. Cohen in our committee a few weeks before that, I asked him, are you going to be ready? Are you talking about delay? Are you going to narrow the scope of the Affordable Care Act? Absolutely not, we are on target, we are going to be ready. You said some of the same things this morning. And yet on July 2nd we are going to delay the individual mandate by a year.

So, again, can you understand our discomfort? You are supposed to be in charge of the administration of this program and yet it doesn't seem like you are.

Ms. TAVENNER. Well, I am very much in charge of the administration of the marketplace.

Mr. BURGESS. Great. Then you will provide us the information and the chain of information that came forward to your chief of staff as to how you were informed about that decision. I would also be interested, did you push back on that at all and say, "Hey, this

law was perfect the way the President signed it in March of 2010." Did you push back against the West Wing at all about that?

Ms. TAVENNER. I am happy to get you that information.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. All right. And my time is limited, let me move on to something else: 100 percent review for people who are under the self-attestation. That is great. I am glad to hear that. So how is subsidy recapture actually going to work? Someone on January 1st of 2014, is their subsidy based on what they earned in the previous calendar year? Because they won't have filed their income taxes yet. Are they going to tell you how much they are going to earn in calendar year 2014 for that subsidy? How is that actually going to work?

Ms. TAVENNER. If their income is unchanged from what they filed on their income tax, obviously it is based on that. If they have new information, they would provide us that and we would base it on their projected income for 2014.

Along the same line, part of the instruction to a consumer, someone signing up for tax credits, is if they suspect their income is going to change, or it does change, then they have a responsibility to notify us.

Mr. BURGESS. Do they understand that the subsidy is paid to the insurance company for which they register to have insurance, but if there is an overpayment, if there is subsidy recapture, the individual, not the insurance company, the individual will have to pay that back. Do you think people have an understanding of that?

Ms. TAVENNER. Yes, that will be part of the——

Mr BURGESS. No, they do not. I will just tell you they don't because I have asked in this committee other people who are signing up for insurance.

When can Texans expect to go online and be able to get information about how expensive coverage will be in the exchange?

Ms. TAVENNER. So the information about what is available in the exchange will be available to them October 1.

Mr. BURGESS. So we won't know what our insurance is going to cost until October 1?

Ms. TAVENNER. The rates will be available in September. But I thought you were asking when an individual could actually go online.

Mr. BURGESS. I will just tell you, we have heard a lot about constituents coming to town halls and asking questions. I went through your Web site sitting here at the dais, and the answer that I got was, your search returned zero plans, please check back later. That is what our constituents are seeing today if they go on your Web site to find out how much their insurance is going to cost in October.

Thank you, Madam Chairwoman.

Mrs. BLACKBURN. The gentleman's time has expired.

Ms. Castor, 5 minutes.

Ms. CASTOR. Thank you very much.

And welcome. I want to thank you for your oversight of implementation of the Affordable Care Act. It is so meaningful for my neighbors in Florida, in the Tampa Bay area. It has given them the

economic security that they need in what is a difficult economy. It is lowering costs, improving benefits.

And I wanted to share with you in the greater Tampa Bay area just some of the statistics. First are my older neighbors on Medicare, it is pretty impressive. Over 77,000 of my older neighbors that are on Medicare have seen their drug costs lowered since 2011. That has put over $100 million back into their pockets. Very meaningful indeed.

For those Medicare beneficiaries now, it is so important that they can go get the mammograms, the colonoscopies without the copay, and they are taking advantage of it. Because of this provision in the Affordable Care Act, over 1 million seniors in the greater Tampa Bay area have been eligible for those services without a copay, without additional co-insurance or deductible.

And then most people have insurance. If you have private insurance, and in my district alone I have kind of a younger community with a lot of college students, but when you look at the greater Tampa Bay area, we have almost 50,000 young adults that have been able to stay on their parents' policy. These are the parents and students I run into in the grocery store, the ones that call me, and they are now connecting the dots, yes, this was because of the Affordable Care Act.

In the greater Tampa Bay area, over 1 million individuals in the private plans also have better insurance and preventative services. And I love this number, this is one of my favorite ones: Almost 1 million individuals in the greater Tampa Bay area have received those rebate checks. And this is one where there is a little bit of a disconnect, and they get that rebate check from the insurance company and they don't know it is because of the Affordable Care Act. So we have work to do to connect the dots there. That has brought $47 million back to many of my neighbors throughout my community. And I know that there is more to come this summer, correct?

Ms. TAVENNER. That is correct.

Ms. CASTOR. You have been very measured in your testimony today. But I have to tell you, I get very distressed and almost upset when you think about the political theater up here. We are going to have another vote tomorrow, for the 40th time, to repeal these rights now that consumers have, the more meaningful insurance, those rebate checks, the fact that people with cancer and preexisting conditions can actually get insurance for a change.

And in Florida we have, you know, it appears that it almost does border on sabotage, to say to this consensus of the business community, the Florida Chamber of Commerce, the associated industries, consumer groups, the Republican-led Florida Legislature said we are not going to take the Medicaid expansion, even though that is our tax money, $50 billion over the next 10 years. It is outrageous.

But were you also aware that the Republican legislature in Florida has tied the hands of our insurance commissioner to negotiate the new rates? Now, we are going to have a Federal exchange, but most States allow their insurance commissioner to negotiate rates. And just recently in Maryland, it is obvious that because the insur-

ance commissioner had the ability to negotiate rates that the new premiums, rates came out, and they are much lower.

So I would like to ask you, what do you think of that? Our Office of Insurance Regulation, the good news is that in my home county, Hillsborough County, there are going to be 82 plans for people to choose from, six different health insurance companies. It is the same across the Bay in St. Petersburg and Pinellas. But why would you tie the hands of your insurance commissioner to regulate rates? And then what role will you have now in the review of those rates going forward?

Ms. TAVENNER. So I obviously can't speak to what is going on in Florida. I will tell you that we do have good working relationships with each of the commissioners, and so we try to help them. Also, that is exactly what is going on in August. States on the Federal exchange are submitting their proposed rates now, and we will be doing a review, working with each State during the month of August. And then obviously those rates get published in September.

Ms. CASTOR. And, you know, one of the other things they did, they passed a law that said there is going to be a State report on the rates, but they barred the insurance commissioner from taking into account the actual tax credits and subsidies. So here is the warning for Floridians: When you see the information you are going to have to dig a lot deeper because it is likely what will be published, the misinformation campaign, will not be the reality on the ground at the end of the day.

Thank you very much.

Mrs. BLACKBURN. Gentlelady yields back.

Dr. Gingrey, 5 minutes.

Mr. GINGREY. Madam Chairman, thank you so much.

First of all, I would like to thank Administrator Tavenner for appearing before the Energy and Commerce Committee today.

With 60 days until the insurance exchanges have to be ready, we still, unfortunately, continue to see headlines that insurance costs will be going up and people purchasing through the exchanges will have fewer options.

Just this week, Administrator, the insurance commissioner in my home State of Georgia, Ralph Hudgens, announced that we could see rates rise as much as 198 percent. On average, it is not a pretty situation. For an average 27-year-old male, premiums are set to rise 85 to 198 percent within the exchanges, while for a 45-year-old premiums will rise 40 to 100 percent.

And even an adult, an older adult just before the Medicare eligibility age will pay 18 to 48 percent more in the Obamacare exchanges.

This is not just a Georgia problem, Madam Administrator, we have heard from a number of States that, believe it or not, the exact scenario we have been talking about since this bill was passed is occurring and people will be forced to spend even more money on their monthly premiums.

Did you expect to see such a rise?

Ms. TAVENNER. This is not what we are seeing across the country. Obviously, we have as many stories or probably more stories of where rates have actually come in lower than expected. And as I stated earlier——

Mr. GINGREY. Well, Madam Administrator, of course I am concerned about the entire country, yes, but I am especially concerned about Georgia.

President Obama campaigned that his plan was going to lower premiums across the country by $2,500 a year, and here we are 3 years later with premiums higher by $3,000 with a large jump expected again next year.

Do you expect there to be a time soon where we ever see premiums begin to drop across the country, including my State of Georgia?

Ms. TAVENNER. Yes, sir, I do. And that is why the competition and transparency are so important.

Mr. GINGREY. Listen, I appreciate that, and I hope you are right. I hope and pray that you are right.

I also would like to point to the front page of this morning's Atlanta Journal-Constitution, you may have seen this, Madam Administrator, where the top headline reads, "Insurance Options Shrink." The article follows on the announcement yesterday that Aetna and Coventry will not be offering insurance through the exchanges next year in Georgia in any of the 16 regions.

Are you worried about a lack of competition in the exchanges?

Ms. TAVENNER. We have certain isolated incidences where we have fewer subscribers. In Georgia we are fortunate, we still have six plans. Even with Aetna and Coventry's withdrawal you do have good competition.

Dr GINGREY. Well, I am glad that you have a concern because I certainly do, and as I pointed out and you just mentioned, there are the 16 insurance regions in Georgia. Georgia is a big State, 10 million people. Two of these regions have only one insurance option, and in 8 of the 16 there are only two options. Thank goodness Blue Cross Blue Shield is going to offer an option in all 16 regions. But it is the only health insurance company that is doing that. And it seems to me that this is no way to foster competition and encourage better and cheaper options for consumers.

Would you please help the committee to understand how citizens from the State of Georgia will be benefiting from higher costs and a lack of competition on these exchanges other than to dole out Federal subsidy money by self-attestation? You tried to assure us earlier that maybe that wouldn't be the case, but tell me a little bit more about your concerns.

Ms. TAVENNER. What we are seeing nationwide is actually more plans entering the market. So we are seeing an increase in competition, which is what we expected to happen. We have already said this process would take a few years, more and more companies will get interested. And we certainly think that will be true for Georgia. And we are pleased that Georgia has six plans and is covered.

Mr. GINGREY. Well, my last comment to you is in regards to the lack of a response. And this article I just referenced this morning in the AJC, Atlanta Journal-Constitution, to our insurance commissioner Mr. Hudgens regarding his request for an emergency 30-day delay for the submission of his rate review.

While I understand there was a tight timeframe given for a response, I find it unacceptable that the health and human services

commissioner has still not offered even a preliminary response to his request, especially since yesterday was the deadline for submission.

So if you will take that message back to her, Madam Administrator, I would really appreciate it. The commissioner of insurance in Georgia, Ralph Hudgens, needs an answer and PDQ.

Ms. TAVENNER. Yes, and I understand that they were able to clear more plans yesterday. So we appreciate the commissioner's hard work.

Mr. GINGREY. Thank you very much.

And, Madam Chairwoman, I yield back.

Mrs. BLACKBURN. The gentleman yields back.

Dr. Christensen, 5 minutes.

Dr CHRISTENSEN. That you, Madam Chair.

And welcome, Administrator. We are glad to have you fully on board and look forward to working with you. And you may know that the Congressional Black Caucus is out in different districts helping to inform our constituents about the Affordable Care Act, the benefits that they have had, such as were recounted by my colleague, Ms. Castor, and what they can expect and how to access what will be available in 2014.

I also just, before I ask my question, want to refer my Republican colleagues to our Democratic memo, which really demonstrates that the dire predictions about insurance premiums are not really what is panning out in reality.

My question comes from my recent visit with the National Medical Association. Many of the newly insured will be minorities. And because they have not had ready access to health care, as even was reported by the most recent national health disparities report by the, Agency For Health Care Research and Quality, so they are going to be sicker, they are going to have multiple chronic diseases, exactly what the accountable care organizations, medical homes, and those new formations are meant to address.

The doctors that I met with are really concerned about their being left out of the ACOs that are being planned in their areas, as happened with many of the HMOs. And we know how important concordance of cultural, racial, ethnic, and linguistic concordance is between the patient and provider in terms of outcome.

So I know you are just recently confirmed, but you have been at CMS for a while. Do you know what has been done to reach out to black, Hispanic, Native American, and Asian health providers, who just like their patients may need special outreach and maybe some more support to make sure that they are able to fully participate and their patients benefit?

Ms. TAVENNER. So a couple of things. Obviously, as we move forward with the exchanges of the marketplace, there is considerable amount of energy, funding, campaigning that is targeted to African-American, Hispanic, and overall uninsured. So that is one area in our marketing.

In our education, the work that we are doing with navigators, the navigator awards will be made on August 15th, and part of looking through those awards is making sure that our navigator awards match the individuals who have expertise in that area. So that is a second area.

A third area, as we see ACOs and medical homes grow, we are starting to push on this issue of making sure we are hitting the underserved communities, particularly those with higher minority populations. So we are coming at it from several fronts and we are very interested in getting it right.

Mrs. CHRISTENSEN. Thanks. I would hope that the Office of Minority Health at CMS is involved, and perhaps we would like to maybe bring a few of the representatives of some of these organizations over to meet them.

Ms. TAVENNER. We would welcome that. And the Office of Minority Health is very involved. And in fact Cara is a member of our senior management team, so she is at every meeting right there with us.

Mrs. CHRISTENSEN. Thank you. And many of us have been concerned for a while and interacted with CMS over the years on issues about service and care for patients with end stage renal disease. With private insurance there is a period of time where the private insurance can continue before they go over to Medicare. Has this been considered for patients who are in the exchange who may develop end stage renal disease so that there is no——

Ms. TAVENNER. Gap.

Mrs. CHRISTENSEN [continuing]. Gap, barrier, for them to continue to receive their end stage renal disease treatment?

Ms. TAVENNER. Yes. We have been meeting with advocates with the associations and with insurers to make sure that there is not a gap.

Mrs. CHRISTENSEN. OK. The article that Dr. Cassidy, I think it was, referenced, a couple of things, just if you could tell me if they are true or false. ACA takes money from the pockets of each laborer covered by health and welfare funds?

Ms. TAVENNER. I don't think that is true.

Mrs. CHRISTENSEN. It is not. Or they take coverage away from employees who already have it through their employers?

Ms. TAVENNER. No.

Mrs. CHRISTENSEN. OK. And this is the article that was referenced: ACA threatens to harm our members by dismantling multiemployer health plans.

Ms. TAVENNER. No.

Mrs. CHRISTENSEN. Not true.

Thank you, Madam Administrator.

I yield back.

Mrs. BLACKBURN. Thank you, Dr. Christensen.

At this time, Mr. Scalise, 5 minutes.

Mr. SCALISE. Thank you, Madam Chair. I appreciate you having this hearing.

And, Administrator Tavenner, I appreciate you coming to testify. There are a lot of questions that we have, and a lot of them really are rooted in the questions that our constituents have. And with all due respect to some of the answers you have given about the lack of problems that employers are facing, every single day I hear from employers back in my district that have nothing but problems and questions that are unanswered about the President's healthcare law.

And just Monday back in New Orleans I held a town hall meeting specifically focused on the healthcare law, again because we have a lot of people that have these questions. I invited the head of the Louisiana State Medical Society to come and talk about some of the impacts that our medical doctors are having in Louisiana. And I wish you were there because you would have heard some very serious concerns by a packed house, they literally had to bring in more chairs because of the overflow crowd. And first they had the Louisiana Medical Society talk about how this is adversely impacting our doctors in Louisiana, this interference between the doctor and patient relationship.

They had actually written an article about the expansion of Medicaid and the problems that that causes. In fact, they talked about the lack of ability for many doctors to even see new Medicaid patients because of the reimbursement rates and all of the problems in Medicaid. Medicaid is probably the most broken part of health care. And yet President Obama wants to put another 30 million people on Medicaid.

And then when we heard some of your questions, especially as it relates to employers that are being forced to reduce their workforce and also to reduce the number of hours of their workers because of the requirements and their inability to comply with components of this law, you seem to have a disconnect where you act as if you are not aware that this is going on.

Are you aware that employers across the country, clearly employers in my district, every single day are saying one of their biggest impediments to hiring more people, in fact one of their biggest impediments to keep in the current workforce they have is the President's healthcare law?

Ms. TAVENNER. What I am saying to you—and I have spent time in your State, both in Baton Rouge, New Orleans, I have talked with hospitals, I have talked to physicians, so I have been involved in the States. And that is one point I want to keep making over and over again: I am out there, I am listening. I do hear isolated incidents of individuals trying to cut back hours. I don't hear so much about reducing——

Mr. SCALISE. Do you really think that is isolated? I hear it every day and it is across the board, large employers, small employers, medium-size employers that are all saying the same thing. Rarely do you get that, competitors, people that compete down the street from each other saying the exact same thing about being forced to reduce their workforce. They don't want to do this. They love their employees.

Their employees have good health care. By the way, one of the broken promises of President Obama, if you like what you have you can keep it. I don't know if you have seen, and I know—I think Dr. Murphy pointed out the article in the paper from the various unions, there was a letter written by James Hoffa, president of the International Brotherhood of Teamsters, Joseph Hansen, International President of UFCW, and D. Taylor, president of UNITE–HERE. Let me read you some of the comments because it sounds like you haven't heard this. And these are people, by the way, that pushed for this law to be passed. They were not opponents of the President's healthcare law. They were active supporters.

They said, the ACA, the Affordable Care Act, "will shatter not only our hard-earned health benefits, but destroy the foundation of the 40-hour workweek that is the backbone of the American middle class." That wasn't Steve Scalise or some other conservative Republican that voted against the law. This is the head of the unions that helped push this saying it will destroy, the President's healthcare law will destroy the foundation of the 40-hour workweek, which is the backbone of the American middle class.

And then you are testifying that this is some isolated incident. I mean, are you aware that they wrote this?

Ms. TAVENNER. Yes.

Mr. SCALISE. Have you seen some of the other things they have said? "We have been bringing our deep concerns to the administration...our persuasive arguments have been disregarded and met with a stone wall by the White House and the pertinent agencies."

Again, this isn't some right-wing group. This is James Hoffa of the Teamsters saying that you all have been stonewalling their concerns, and then you are testifying saying these problems are isolated. And it seems like you are living in some cocoon where you think and you say in your testimony, "Two months from today, the Health Insurance Marketplace will be open for business, giving consumers an easy way to compare and enroll for affordable health insurance coverage." And again the President just admitted this thing is not working when he delayed the employer mandate. I think you even said that the delay of the employer mandate could greatly contribute to the integrity of employer verification in the future. Did you write that or put that in a rule?

Ms. TAVENNER. I am sorry, could you repeat that?

Mr. SCALISE. That the delay of the employer mandate could greatly contribute to the integrity of the reporting sections under 55 and 56 of the code, the employer mandate could greatly contribute to the integrity of the employer verification in the future. And as the President, and supposedly they didn't consult you, but as they decided to delay that employer mandate, does that jeopardize the integrity of the employer verification in the future? Because that was a concern you raised.

Ms. TAVENNER. No, it was not a concern I raised. I said the delay or the transitional or whatever we are calling it, the delay of 1 year the employer mandate does not affect the implementation of the marketplace or the exchange——

Mrs. BLACKBURN. The gentleman's time has expired.

Mr. SCALISE. Thank you. I yield back the balance of my time.

Mrs. BLACKBURN. Mr. Sarbanes.

Mr. SARBANES. Thank you Madam Chair.

Thank you for being here. I appreciate your time.

I think our colleagues on the other side of the aisle are in a difficult place right now because they know that if this works it is going to do really great things for their constituents. So they are in this weird position where they are hoping it won't work but they don't want to really say that, so they keep bringing data and information and evidence of problems that are really part of the old system that don't bear the impression yet of the Affordable Care Act and the change that it can make.

If you look at the things that have actually taken effect already, I mean, the exchange is not in place yet. So if you are talking about premiums and what they are out there that are happening today, you are talking about something that exists prior to the implementation of the exchanges.

The stuff that the Affordable Care Act contain that has already taken effect actually are working pretty well, like keeping young people on their parents' insurance coverage until age 26. That has worked. Hundreds of thousands are benefiting across the country, the young people themselves and their families who don't have the anxiety attached to that anymore. You look at the reduction in out-of-pocket expenses because we have eliminated some copayments for our seniors for certain kinds of preventive screenings and other things. That is working and being embraced by the audience that is benefiting from it.

So if you were to look at the thing, if you were to say, projecting forward based on the experience of provisions that have already taken effect, how they have been received and how they are working, can we be optimistic that there is good things to come, you have to say yes about it.

Now there are projections being made, insurers are starting to come forward and indicate what the cost would be in the exchange. And Maryland, according to data we got a hold of, the average per-person monthly premium in the individual market in 2010 was $219, slightly over what the U.S. average was. Under rates that were released last week for what would happen in the exchange where you get the benefit of this pooling, the rates would vary from $114 for the Bronze plan for a 25-year-old, up to $269 for a Silver plan for a 50-year-old. Those are pretty good rates by comparison. And that doesn't even account for the subsidies that are going to be available.

So in those States, frankly, where the leadership embraced the Affordable Care Act, has been working closely with your agency to make sure that we have a good launch, the projections are pretty good.

The question I wanted to ask you is, I guess there are three categories of States in terms of how they have responded to the challenge of the exchanges. The one who have really embraced and said we are going to go out and do this, we are going to make it work. Maryland is an example of that, I am proud to say. There are States that I guess are going to be in a kind of joint capacity with you all.

Ms. TAVENNER. Right.

Mr. SARBANES. And then there are the ones that completely resisted it. And, you know, you are going to have to kind of step in and make it work.

Presumably, in places where people have been embraced this, the prospects of the launch of this and the implementation going well, are going to be better than in places that were very resistant. And a lot of criticism of what is coming and projection of these doomsday scenarios, frankly, are coming from Members and others from the States that have been completely resistant to it, which I imagine is a little bit maddening for you. But maybe you could, in the

last 30 seconds of my time here, you could just kind of talk about the distinctions of having to grapple with those three categories.

Ms. TAVENNER. Yes. Let me start by saying even those States that have been resistant that are in the federally facilitated exchange, that when I meet with individuals in those States, there is a great deal of enthusiasm of helping us, advocates, social services departments, hospital associations. And we have individuals who are going to be trained, who are going to help people sign up who want this law to pass, because they are frustrated with having individuals come in and saying, you can't get health insurance because of a preexisting or you can't afford your health insurance. So they want to help. So even though they are in a federally facilitated exchange, there is a lot of enthusiasm at the ground level.

Large employers certainly have some concerns, and I have met with them and we have discussed those concerns and we have talked about how to manage. But they are also pleased to see the cost trends.

So even in States that have not actively embraced the State-based exchange, there is a lot of on-the-ground enthusiasm, and that is where the navigators and the in-person assisters will be so helpful to those States.

Mr. SARBANES. Thank you.

Mrs. BLACKBURN. Gentleman yields back.

Mr. Latta.

Mr. LATTA. Thank you very much, Madam Chair.

And, Madam Administrator, thanks very much for being with us today. It has been, I am sure, very interesting for all of us hearing your testimony. And it is also interesting to me because, again, listening to my fellow Republicans on this side of the aisle, some of the questions they have asked, and especially about how it is affecting their individual districts when they are out. And I know that some of the Members have already heard me say this, but the number one issue when I am out in my district when I talk to my businesses, small and large, is about Federal regulations. And now with the Obamacare coming on, it is really front and foremost in a lot of people's minds. And I would like to give you a couple of examples here.

First, I represent a district that has 60,000 manufacturing jobs—again, large and small. I also represent the largest ag district in the State of Ohio, which is kind of an interesting way to have a district, but I am very, very proud of it.

I also have a lot of entrepreneurs out there that really want to get out there and employ people. But when I have had over, according to my office, over 330 meetings at businesses and factories with farmers and across the spectrum at universities, schools and colleges, and also with hospitals, they are very, very concerned about this law, especially what is happening, especially when I heard that you are saying you only know of isolated instances. So maybe what I could do is kind of point out more that what I am hearing, because we are on the road in our districts all the time.

And one of the things also I find interesting is that from the CBO, when they said recently that we are still going to have 31 million people uninsured in 10 years, and is that correct?

Ms. TAVENNER. I am sorry, I don't know what which one you are referring to.

Mr. LATTA. With the Congressional Budget Office, when they came out with a report that we are still going to have 31 million people still uninsured in this country in 10 years?

Ms. TAVENNER. I am not familiar with that.

Mr. LATTA. OK. I advise you, if you can look that up.

Let me give you a couple of examples, because again, since you said that you are really not aware of these isolated instances, again, we are the ones that spend our time in the car in our districts. One report that came out from one of our local television stations about a gentleman that they interviewed that he worked at a restaurant, that he is going to have his hours cut because the owner of the restaurant said they just couldn't make the payment when it came on the insurance side. And so what is going to happen to him is going to happen to a lot of people in this country. The owner tried finding other ways of cutting hours instead of cutting the employees, because he wanted to make sure people have a job. But the problem is now in this gentleman's case is that he is going to have less than 30 hours that he will be working a week and the worker reported that he will lose about $400 a month with fewer hours having to pay the health insurance. And when he said he added it all up, he is going to have $27.50 a week to live off of.

These are not isolated incidences out there.

Let me give you another example. I am getting calls from colleges and universities. I am very blessed to have quite a few in my district. These universities and colleges are calling me saying that the folks out there, these students, are having their hours cut right now, and they are getting fewer hours. So it is not only that they are not going to have problems getting health insurance, but the other problem they are going to end up with, they are going to have fewer dollars to be able to pay for their tuition. That is not an isolated incident. That is going across my district.

Give you another example. I went to two companies not too long ago, and it is very odd it was back to back with both of these companies, one had 35 employees, the other had 45 employees. The one with 45 employees had a business that could expand right now and they said they could double their business and double the amount of employees up to 90, but they are not going to do it. Why? Because they will not expand over the employer mandate of 50.

So what protections out there are we going to have, especially on the administration side, what protections from these penalty increases do employers have if they choose to pay that penalty? Are we going to see this penalty increasing? What is going to happen to those folks, for the employers?

Ms. TAVENNER. I will give you an isolated incident back about the Affordable Care Act. I met with an individual this past weekend who was employed State government, lost his job. He is an attorney. He is back on the individual market. So he is paying $1,500 a month for his insurance. His agent called him last week to let him know that with the Affordable Care Act he could look for that to halve because he would have some buying power in the small market.

So when I say isolated incidences, I have met with large employers in Georgia, in Florida, I have met with small employers. I have been all across this country and I will continue to do so. And I will try to work with them. But there are stories of both examples, and that will continue to be the case.

Mr. LATTA. Madam Chair, my time has expired and I yield back.

Mrs. BLACKBURN. The gentleman yields back.

Mr. Green for 5 minutes.

Mr. GREEN. Thank you, Madam Chairman.

Madam Administrator, I am a supporter of the Affordable Care Act, and I represent a district that has some of the highest in the country of people who work and are uninsured because their employers don't provide it. It is in Houston, Texas. And so we have a lot of challenges. And I know implementation of the ACA is a work in progress, but I am encouraged by the good news on rates from States like Maryland, New York, and California.

My first question is, what is the Federal Government doing to set up our national exchange in Texas? And when the federally run marketplace is operational in Texas, can my constituents count on some of the same things we are hearing on rates that would be in New York or Maryland or California, high quality health insurance?

Ms. TAVENNER. Yes, you can. And, in fact, we work closely with the Texas insurance commissioner. They have submitted their rates, they are on the Federal exchange. They have submitted their rates as of yesterday, as a matter of fact——

Mr. GREEN. I didn't know we had—excuse me—I didn't know we had a rate, we have never regulated rates in Texas.

Ms. TAVENNER. Well, they submitted the plans, they are going to participate on the exchange. We will be reviewing those in the month of August and then those rates will be public in September.

I have also spent a fair amount of time traveling in Texas, and will be back in Texas, because Texas is a huge population with a huge number of people who can be benefited from the Affordable Care Act. And when we release the navigator grants later this month, there will be a lot of people on the ground in Texas helping get folks signed up.

Mr. GREEN. OK. And I am disappointed in our Governor and our legislature not being able to expand Medicaid. It will leave a lot of my constituents without access to health care.

One of the concerns I have, the politics of the Affordable Care Act and Medicaid expansion has no place in our DSH procedures. And your office and myself, plus a number of Members, have been working on a problem we have with certain children's hospitals, one in Houston, Texas, but also in other parts of the country. I appreciate your work on that. I just heard that CMS has rejected any efforts on that.

My concern is, is that because Texas made a decision to reject Medicaid expansion or set up an exchange or partnering exchange, that shouldn't have any influence on the decision that we are working on for the children's hospitals. And let me talk a little bit about that.

Our office and members of the committee, that CMS regulations are now saying that freestanding children's hospitals are required

to declare payments received from patients with private payers who, if they didn't have that private pay, would be counted as they would be under Medicaid. But since they have it, CMS has made the decision now that they are going to count those private payers as reductions in, frankly, Texas Children's Hospital in Houston. That would wipe out their DSH funding. We are fortunate, thank goodness, that we have some folks who can be covered who, if they weren't working, didn't have insurance, they would be under Medicaid. It seems like it is, you know, why would you count them against their Medicaid allocation and hurt their DSH funding?

I know we have tried to work together, but I just heard that there was a decision made, and I would hope you would continue and CMS would continue and delay that decision until we can find out a way we can do it. If we can't do it administratively, it is a bipartisan issue, we will have to find some vehicle to do it. But it seems like you are punishing folks, children's hospitals, who have an opportunity to have these folks to have insurance. And if they didn't they would be under Medicaid and they would be counted. I don't know why that decision was made.

Ms. TAVENNER. Well, I will continue to work with you and I can come meet with you on that topic. But one thing I will remind you on Medicaid and the DSH is it is in the President's proposed budget to delay the Medicaid DSH funding cuts—separate issue, but obviously affects your facilities—for 1 year to give States such as Texas an opportunity, if they decide to pursue the Medicaid expansion.

So we understand that some States might not be able to do it in year 1, but may be able to be on board by year 2, so the President is trying to take that into consideration.

Mr. GREEN. And we would hope by year 3 or 4 or 5 that a lot of these folks who show up—although in Texas, because we have a very lean Medicaid program, they may not even be qualified for that. So, anyway, I appreciate your working with us. And also I wanted to keep in touch on what we are doing to roll out, because a lot of us in Texas are planning to do a lot of aggressive effort over the next month, and even into September, for October 1st.

Ms. TAVENNER. And I will say your hospital association has been wonderful working with us.

Mr. GREEN. OK. Thank you.

I yield back the time.

Mrs. BLACKBURN. The gentleman yields back.

Mr. Lance, 5 minutes.

Mr. LANCE. Thank you, Chairwoman Blackburn.

Good afternoon to you, Administrator. I have not met you. I look forward to working with you. Congratulations on your appointment, and congratulations also on your confirmation, not an easy feat.

Regarding Medicaid, it is my understanding that, whether or not a State has decided to participate in the Medicaid expansion, all States are now required to use a single streamlined Medicaid application. Is that accurate, Administrator?

Ms. TAVENNER. That is correct.

Mr. LANCE. And as I also understand it, the application requires CMS approval and must be compatible with the application for the

Federal exchange. And I believe that this streamlined application is supposed to be available for consumer use by October. Have you yet approved the streamlined application or when do you expect to be able to approve such application?

Ms. TAVENNER. So the streamlined application has been back and forth, posted for public comment, et cetera, and it will be approved and available, the final, the end of August.

Mr. LANCE. By the end of August, and that will give States roughly a month before it goes into effect in——

Ms. TAVENNER. Many States have already agreed to accept this application. There are some States who want to do their own, and we are working with those and approving those. But they will be approved before October.

Mr. LANCE. Thank you. And as a matter of information, do you know where New Jersey is in that?

Ms. TAVENNER. I do not, but I can certainly find that out.

[The information appears at the conclusion of the hearing.]

Mr. LANCE. Certainly. Thank you very much.

Regarding the President's decision, or at least the administration's decision to postpone for 1 year the effect of the law as it relates to large employers, that was a decision of the Treasury, is that right?

Ms. TAVENNER. Yes. There are many pieces of the Affordable Care Act that rest with different agencies, and that rests with them.

Mr. LANCE. And did CMS have any involvement in that? Were you advised or did you give your position on that before the decision was made by the administration?

Ms. TAVENNER. No. We were not asked to provide input. We were advised.

Mr. LANCE. I see. Thank you.

Regarding the navigators, as I understand it, they cannot receive direct or indirect compensation from a health insurer, is that accurate, Administrator?

Ms. TAVENNER. There is some conflicts of interest involved in the navigators.

Mr. LANCE. And regarding donations, is a nonprofit group permitted to receive donations from health insurers regarding navigators?

Ms. TAVENNER. So navigators are funded through CMS.

Mr. LANCE. Absolutely.

Ms. TAVENNER. So that is actually separate and apart.

There are some, I am sure, insurers are also working on their own marketing campaigns. I am not aware of any overlap, but I can certainly ask that question.

Mr. LANCE. Thank you. I have a concern as to how they will be paid and how the compensation will be determined and will there be any amounts that might be deemed too high for a navigator, for the payment of a navigator, and would this result in the application's being rejected? That is all currently being worked out?

Ms. TAVENNER. Yes, it is. And they will be awarded around August 15th. But that is part of what we look at today, because they have to follow all the Federal contracting rules, et cetera.

Mr. LANCE. And we will be advised of that as these contracts are awarded in the middle of August?

Ms. TAVENNER. Yes.

Mr. LANCE. Thank you very much, Madam Chairwoman. I yield back half a minute.

Mrs. BLACKBURN. Excellent.

Mr. Engel, 5 minutes.

Mr. ENGEL. Thank you, Madam Chair.

Administrator, welcome. I am sorry, I wish some of my friends on the other side of the aisle would stop badgering you. They ought to get over it. The Affordable Care Act was passed, it was signed into law, and the 2012 Presidential election was largely held on that. And the last time I looked the President won and the Republican nominee lost. And we ought to understand that the Affordable Care Act is here to stay. This committee played a very important role in the affordable healthcare act, and I am proud of the role we played, and I think that history will vindicate us in terms of it.

Some of my colleagues asked questions about rates. They are concerned about rates. My home State of New York long ago implemented numerous important consumer protections in the individual health insurance market, including community rating and requiring insurers to provide coverage for those with preexisting conditions. And unfortunately, without an individual mandate to purchase insurance, New York's health insurance rates have historically been very high. Therefore, I was very pleased to see the anticipated rates released last month for New Yorkers, it was the lead story in The New York Times, seeking to purchase health insurance in our State-run exchanges. On average the approved 2014 rates for even the highest tier plans represent a 53 percent reduction compared to last year's individual rates. Furthermore the average approve rates for the benchmark individual Silver plan in New York are nearly 10 percent lower than the nationwide average previously forecast by the CBO. These reductions don't take into account the subsidies that will be available for many New Yorkers purchasing coverage on the exchange, which will lead to even lower costs.

So these results tell a far different story than the claims of rate shocks that we have heard from many Republicans on this committee. Moreover, far from the Republican myths about the ACA resulting in a government takeover of health care, the free market is thriving. There are 17 insurers who have been approved to participate in our exchange, including eight carriers who are participating in the New York market for the first time.

So, Administrator, can you elaborate on the importance of the individual mandate for reducing costs and helping enroll people in both private insurance and Medicaid? And some of my Republican friends on this committee have suggested that the individual mandate, like the employer mandate, should be delayed for a year. What would be the impact of a delay of the individual mandate?

Ms. TAVENNER. Well, I think you have actually outlined some of that for me. The importance of the individual mandate is that we need all individuals to participate to spread the risk so that we can have competitive rates. And it actually is the foundation for the

work that is going on with the establishment of the marketplaces, very different than the employer mandate.

We are pleased with New York. New York is an excellent example of new carriers entering the market, being able to decrease rates. We have great working relationships with the insurers. And I would be remiss if I didn't say that. And part of their interest in participating, obviously, is it is a growth market for them. These States represent new strong applicants. They have been good partners for us. So the individual mandate is critical.

Mr. ENGEL. I am going to also congratulate you as the confirmed administrator of the CMS. It is important to have one, and we are glad it is you. I also want to say that some of my colleagues who complained about the President delaying the employer mandate for a year, they complained when he didn't delay it, they complained when he delayed it, they would complain if he did nothing, and they would complain if he worked. So I think it is clear that they are just complaints at this point almost for the sake of complaining.

I wanted to raise something that Mr. Green raised and that is DSH cuts. The Affordable Care Act mandated significant changes to the Medicare and Medicaid DSH program starting in fiscal year 2014, and I am frustrated that many States are choosing to hurt their most vulnerable citizens by forgoing the Medicaid expansion and in some cases actively resisting efforts to make the insurance exchanges successful.

The result of these political games will be that far fewer Americans—uninsured Americans—will gain coverage through the ACA than originally projected, which undermines the very premise upon which the ACA's DSH provisions were based.

So I remain a strong supporter of the ACA, but I am concerned that the ACA's Medicare and Medicaid DSH provisions could significantly impact New York's hospitals and the patients they serve, even though New York is doing all it can to ensure its residents have healthcare coverage.

So could you please generally address CMS' approach to these DSH cuts and their impact on providers and the concerns that I have raised?

Ms. TAVENNER. Yes. Both of those are in proposed rules. Obviously, the President's budget would delay the Medicaid DSH cuts for 1 year. On the Medicare side, we have met with many constituents. We have listened to their concerns. We have reviewed their comments. And we are in the process of making as fair of a process as we can.

Mr. ENGEL. Thank you.

Thank you, Madam Chair.

Mrs. BLACKBURN. Thank you.

Dr. Cassidy, 5 minutes.

Mr. CASSIDY. Ms. Tavenner, I have got lots of things, but first I want to clear up the record some. First, as I gather, you mentioned that the exchanges have been tried, but I have heard confidentially from a State director, not Louisiana's, but he does not want to be identified, that the testing with the States is not going particularly well and there is a growing concern by the States the exchanges will not be ready.

Ms. TAVENNER. So 40 of the States have——
Mr. CASSIDY. I will just say that because——
Ms. TAVENNER. Well, I am challenging——
Mr. CASSIDY. But I only have 5 minutes.
Ms. TAVENNER. I understand.
Mr. CASSIDY. Secondly, also to clear up for the record, you mentioned that you had not heard of anybody decreasing hours in response to the ACA——
Ms. TAVENNER. Actually, I said I had heard of isolated incidents.
Mr. CASSIDY. Yes, so isolated incidents. The Bureau of Labor of Statistics says that involuntary part-time workers increased by $322,000 in June, and that is a trim which has been preceding, so that is the Bureau of Labor statistics. We can get that for the record. The Philadelphia Fed and the New York Fed have both surveyed and let me just quote from the Philadelphia Fed. They are both basically the same, though. "What do you plan to do in the upcoming year in response to the ACA? Six percent are going to fire or refrain from hiring to keep below 50 FTEs, 8 percent are going to shift from full-time to part-time, 18 percent are going to outsource more work." This is objective data from the Fed. I know you have heard of isolated incidents.
Ms. TAVENNER. Congressman Cassidy, I could also present the same number of reports that say the opposite.
Mr. CASSIDY. I have a question for you in just a second. I just have to clear up the record.
Secondly, my folks on the other side are saying that all these rate increases are less than the CBO estimate, but let's just also say that that is not a CBO estimate, it is the Assistant Secretary for Planning and Evaluation, ASPE, and so it is kind of a tortured methodology.
And lastly I would like to point out that my friend from Maryland says, "Oh, my gosh, Maryland is working hard, it is really going well." Actually, the rate increases for their folks, young, single, are estimated to be 150 percent. If that is working well, I don't know what to say about it.
Now, can you show my slides?
[Slide.]
Mr. CASSIDY. I am concerned about what is happening in Louisiana. You may not be able to see that, but if you look at the top—let me see if I can get the slides here, I can't see it—this is a young single guy, 26 years old, he is healthy. And right now—heck, I can't see that, let me just see if I can get that up here—his income is $33,000. His premium currently is about $1,200. His premium is going to go to $2,300. Now, here is a guy whose take home is 33K before taxes, before paying his student loans, before paying for his car, and we are going to charge him 1,000 bucks more.
Go to the next slide, please.
[Slide.]
Ms. TAVENNER. So could I make a comment?
Mr. CASSIDY. I will ask you to comment in just a second. In just a second. I only have 2 minutes left.
Ms. TAVENNER. First of all, those rates are not yet available for 2014——

Mr. CASSIDY. This couple earns $63,000 a year gross, they currently pay $2,400 for their policy. Under the ACA it is going to go up to $8,000, a 211 percent increase. Now, if you were that 32-year-old couple—I would love to be 32 again, I suppose—if one of us were and we had student loans trying to buy a house, maybe planning to have a kid, and you are going to be paying 5K more for insurance, taking things that, frankly, you don't particularly think you need, would you buy that policy?

Ms. TAVENNER. First of all, let me go back. Louisiana rates are not published for 2014, so I am assuming it is speculation.

Mr. CASSIDY. This is a Blue Cross Blue Shield that they have released.

Ms. TAVENNER. Speculation.

Mr. CASSIDY. Well, it is speculation, but I can tell you, Blue Cross Blue Shield——

Ms. TAVENNER. OK. But on the first one I will remind you that I am assured those premiums——

Mr. CASSIDY. Can you tell me five States that you think are going to have lower rates in the individual market than relative to the pre-ACA baseline for an equivalent policy?

Ms. TAVENNER. Absolutely.

Mr. CASSIDY. New York.

Ms. TAVENNER. California. Oregon.

Mr. CASSIDY. No, California, that is not baseline and I can show you that that is comparing to the small group market.

Ms. TAVENNER. So you asked me to name five states.

Mr. CASSIDY. But California is not true. You are being disingenuous.

Ms. TAVENNER. Oh, I am very true.

Mr. CASSIDY. They are comparing—and you know this, Ms. Tavenner, you are so smart—they are comparing relative to the small group market, not to the individual market. It has been shown——

Ms. TAVENNER. So the States would be California, Oregon, Washington, Maryland, New York, OK.

Mr. CASSIDY. Washington? OK. Let's just move on, because frankly we have a question of fact here, but we can clear that up.

Ms. TAVENNER. And by the way, that young guy, he is also eligible for catastrophic, and he can probably get that for 100 bucks a month.

Mr. CASSIDY. OK. That is a nice segue here. We had Mr. Cohen come and testify. He said that only dollars, if somebody took an HSA with a high deductible health plan that as regards calculating the MLR, only the portion of the HSA that was spent—that was spent—would count towards actual expenditures. If the person decides to save that dollar, husband it, if you will, then that would not count as an expenditure, it would count against the insurance company as regards their MLR. Is that your understanding of how the HSA——

Ms. TAVENNER. I am happy to take a look at that.

Mr. CASSIDY. OK, well, that is great.

I have 16 seconds left, but I can't get my next question. I yield back.

Ms. TAVENNER. That 32-year-old——

Mrs. BLACKBURN. Gentleman——

Ms. TAVENNER [continuing]. Is speculative as well.

Mrs. BLACKBURN. Gentleman yields back.

Dr. Olson.

Mr. OLSON. Thank you, Madam Chairwoman, for holding this hearing.

And thank you, Administrator Tavenner, for joining us.

As some of my colleagues already pointed out, there are 2 months until the exchanges are open for enrollment, 61 days to be exact.

Ms. TAVENNER. Yes, I have a calendar in my office.

Mr. OLSON. Yes, ma'am. My own State of Texas has opted to take part in a Federal exchange, and there is a real lack of information about what Texans need to know. The people I represent in Texas 22 are scared of Obamacare. They feel like they have been disrespected and not given information.

A couple of examples. They were stunned when the former Speaker told our Federal colleagues in Congress that they had to vote for the Affordable Care Act so they could figure out how it works later. Stunned. They threw their hands up. When the administration quietly announced that the heart of Obamacare, the employer mandate, was going to be unconstitutionally delayed, they are wondering what is going to happen next? What shoe will fall next?

And these Texans, who are struggling in this jobless recovery, are being told that they are going to lose a quarter of their salary, 25 percent, because of Obamacare's redefinition of a full-time employee from 40 hours per week to 30 hours. They are being called a 29er. They have no idea what that means.

They hear that one of the biggest proponents of this law on Capitol Hill is calling it a train wreck. They find out that last week, and now in The Washington Post today, that the labor unions, big proponents of this bill, this law, wrote a letter to Democrat leadership here in Congress saying that, and this is a quote, the Obamacare "will shatter not only our hard-earned benefits, but destroy the foundation of the 40-hour work week that is the backbone of the American middle class"—"destroy the foundation of the 40-hour work week that is the backbone of the middle class."

All they have heard from the administration for 3 years, 4 months, and 7 days since Obamacare was signed into law is all is well, everything is fine. And, ma'am, you sort of said that today. With all due respect, they are not buying that spin.

I have tried to help my constituents. I went to HealthCare.gov, the page that says how can I get ready to enroll in the marketplace, for some information for them. Here are some of the bullet points it gives to them, profound bullet points. Number one of them, gather basic information about your household income, say your budget. And the one I want to talk about most, ask your employer if it plans to offer health insurance in 2014.

And at the risk of going to a parallel universe, and following the lead of Chairman Pitts, Chairman Murphy, Mr. Terry, and Mr. Scalise, ma'am, every time I have gone home in the 3 years since this bill has been law every single time I go to a small business they have all said—who provide health insurance for their employ-

ees—Congressman, I have a plan to get rid of health insurance. It is good for my business, that is why I got it, I get better employees, I retain them, but I have to compete in the market. And it costs me, I have heard the minimum is $6,000 per employee, per year, minimum. That is twice as much as the maximum penalty they will get under Obamacare. So automatically if one of their competitors drops off, they will have a huge competitive advantage, they will be forced to drop their health care.

And you have said the labor unions, you talked with them. How about a small business back in Texas or any part of the country that says they will have to drop their health care? Yes or no, ma'am?

Ms. TAVENNER. I have talked with lots of small businesses, none of them said they were dropping their health care.

Mr. OLSON. None?

Ms. TAVENNER. None.

Mr. OLSON. That is a parallel universe, ma'am. Come on down to Fort Bend County. It is the most diverse county in America, Hispanic small businesses, Asian small businesses, African-American small businesses, white small businesses, they will all tell you this thing is a train wreck, I am going to probably drop my health insurance because I have to compete. I cannot believe that no one has told you——

Ms. TAVENNER. I actually talked to over 1,000 small businesses in Miami a couple of months ago. And what they are doing is they are trying to learn about the law and see if they can make it work for them.

Mr. OLSON. These guys are trying to make it work, ma'am, but it is not economic, $6,000 per year as opposed to $3,000, that is huge costs savings for a competitor. They will be forced to drop their health care. This bill again is a train wreck. I would love to have you come down to Fort Bend County, Texas, and take you around and meet the small business people I have met.

Ms. TAVENNER. I am happy to do that.

Mr. OLSON. Yield back the balance of my time.

Mrs. BLACKBURN. Gentleman's time has expired.

Mr. Johnson, 5 minutes.

Mr. JOHNSON. Thank you, Madam Chairman.

What did you do, Billy?

Mr. LONG. I don't want to get blamed for this.

Mr. JOHNSON. This is an awfully big seat to sit in.

Ms. Tavenner, my colleague asked you about small businesses that have said they are dropping their health coverage. You said you have not talked to any. We have talked to hundreds, if not thousands, across America. If we give you a list will you add them to your call list so you can talk to some American businesses that are struggling with this? That is a simple—that is a simple—you will either do it or you won't.

Ms. TAVENNER. Of course I will do it.

Mr. JOHNSON. OK. Great.

Ms. TAVENNER. I think anyone would tell you, I have a complete open door policy.

Mr. JOHNSON. Great. All right. Great. We are going to give you that list and get you to call some of them.

Ms. TAVENNER. I am fine to take that list. I get hundreds of emails a day.

Mr. JOHNSON. The preexisting condition insurance program was supposed to last until 2014. You closed enrollment to this recently, Correct?

Ms. TAVENNER. The PCIP program?

Mr. JOHNSON. Yes.

Ms. TAVENNER. Yes.

Mr. JOHNSON. OK. The Early Retiree Reinsurance Program was supposed to last until 2014. You closed enrollment for this in 2011, correct?

Ms. TAVENNER. No, I think they were to last——

Mr. JOHNSON. When did it close?

Ms. TAVENNER. Could I finish my sentence, please?

Mr. JOHNSON. When did it close?

Ms. TAVENNER. They were to last till 2014 or till the funding expired, and the funding expired.

Mr. JOHNSON. When did it close?

Ms. TAVENNER. I would have to get you the exact time. But the funding obviously expired last year.

Mr. JOHNSON. But you have closed it. You have closed it.

Ms. TAVENNER. Yes, because we expended all the funding.

Mr. JOHNSON. The CLASS program, Obamacare's long-term care program, this was actually repealed, right?

Ms. TAVENNER. I think you would know that.

Mr. JOHNSON. I am sorry?

Ms. TAVENNER. I think you would know that. I am taking your word for that.

Mr. JOHNSON. No. You don't know whether the CLASS program has been repealed or not?

Ms. TAVENNER. I said yes.

Mr. JOHNSON. Well, I am asking you the questions, ma'am. You are not asking me the questions.

Ms. TAVENNER. I said yes.

Mr. JOHNSON. Was it repealed?

Ms. TAVENNER. Yes.

Mr. JOHNSON. OK. Thank you.

The 1099 reporting requirements, the need for businesses to report transactions totaling $600, this was repealed as well, correct?

Ms. TAVENNER. I don't know the answer to that one.

Mr. JOHNSON. You don't know the answer to that one.

Ms. TAVENNER. I do not know the answer to that one.

Mr. JOHNSON. Wow. You have lived a sheltered life.

Ms. TAVENNER. I live a busy life.

Mr. JOHNSON. Full implementation of the Small Business Health Options Program has been delayed as well, correct?

Ms. TAVENNER. I am sorry, could you repeat that?

Mr. JOHNSON. The full implementation of the Small Business Health Options Program has been delayed as well.

Ms. TAVENNER. The SHOP program has not——

Mr. JOHNSON. The full implementation.

Ms. TAVENNER. The full implementation. The employee choice has been delayed for——

Mr. JOHNSON. OK. Great. The employer mandate has been delayed as well, correct?

Ms. TAVENNER. For 1 year.

Mr. JOHNSON. For 1 year. OK.

This is six Obamacare programs that were closed early, delayed, or outright repealed. Do you have any knowledge of other parts of the law that currently may need to be delayed?

Ms. TAVENNER. There is another piece of the law that already was delayed, the basic health plan.

Mr. JOHNSON. Do you have any knowledge of any other parts of the law that may need to be delayed?

Ms. TAVENNER. I do not.

Mr. JOHNSON. Have you had any conversations about delaying any other parts of the law besides those that we have discussed, you and I here?

Ms. TAVENNER. No.

Mr. JOHNSON. OK.

Well, you know, I have got a fundamental question. You went to great lengths in your opening testimony to talk about how the Affordable Care Act was going to take care of working families. Yet when the administration determined that Obamacare is not ready for primetime, and I, along with millions of other Americans agree that it probably will never be, the decision was to delay the employer mandate. In other words, protect big business over working families.

Can you please explain to me and this committee and ultimately the American people why the administration chose to delay the employer mandate, but they are leaving hard-working American families out in the cold and still struggling to figure out how they are going to comply with the individual mandate?

Ms. TAVENNER. I see that as quite the opposite. What the exchanges and marketplaces will do will allow hard-working families who today cannot get insurance——

Mr. JOHNSON. But they are not even—your Web site doesn't even tell them how they are going to enroll in these things. And you tell us that it won't be available until the 1st of October.

Ms. TAVENNER. Yes.

Mr. JOHNSON. I mean what are working families that have to live by a budget—see, we understand that the administration doesn't buy into the idea of a budget, but the American people do. And they sit around their kitchen and dining room tables, and they have to learn to live by a budget. How are they supposed to figure out what they are going to be paying and not paying if you are not going to have this stuff ready until the day the law goes into effect?

Ms. TAVENNER. Well, a reminder that the day the law goes into effect is 3 months prior to coverage actually starting. So they will actually have information in October and can begin to enroll in October for coverage that begins in January.

Mr. JOHNSON. Well, I submit that the administration and your Department have made it very clear that your support is behind big business, it is not behind hard-working American families as you have tried to indicate that it is.

And with that, I yield back.

Mrs. BLACKBURN. The gentleman yields back.

Mr. Long for 5 minutes.

Mr. LONG. Does my 5 minutes start after I sit down?

Mrs. BLACKBURN. Yes, sir.

Mr. LONG. Thank you.

And thank you for being here today, giving your testimony.

And for the record, I have been here 2 hours and 42 minutes. I took about 3 minutes to walk out and get a cup of coffee in the breezeway out here. But when we have these committee hearings I try and attend them, and I try and stay, because I really try and drill down and figure out what the real problems are. And I think that you and anyone else would agree that there is a lot of problems with the implementation of this bill. The bill, if I remember right, was 2,600-some pages. I am 6'-1". I have got a picture of myself standing by the regulations so far that have been written for this bill that are about a foot and a half above my head stacked flat on the floor, the regulations.

And unfortunately, on the other side of the aisle, where there is one person now, people come in and sit down, you know, hit and run I call it. They come in and criticize what we are trying do on our side of the aisle here, and they haven't even heard the testimony. They don't know what we have heard from people, they don't know what the other members have asked you. So I appreciate you sitting through the full 2 hours and 45 minutes, because I did miss 3 minutes of it.

And I believe during one of those questionings the gentlelady from the Virgin Islands asked you about this ad that is in today's paper. And actually, this is an ad in today's Washington Post, but it is a copy of an editorial that was in the Wall Street Journal back July the 12th. And I think, and correct me if I am wrong, but she said, the Affordable Care Act threatens to harm our members by dismantling multiemployer health plans. That is from the International Brotherhood of Electrical Workers. And you said that is not right, correct?

Ms. TAVENNER. I said I do not agree with that, that is correct.

Mr. LONG. Yes. OK. I don't want to put words in your mouth. And then she also said that, according to the National Treasury Employees Union, that it will take coverage away from employees who already receive it through their employers. And you don't agree with that either, do you?

Ms. TAVENNER. Well, I think what you are referring to here is some of the Taft-Hartley. And most of those employees are not eligible for tax credits. And I will remind you it is a very small individual——

Mr. LONG. Take coverage away from employers who already receive it through their employer.

Ms. TAVENNER. I don't understand that statement.

Mr. LONG. OK. But I was thinking that you had disagreed with it earlier.

How much time we got? Two-and-a-half. OK. Here we go.

With those two things fresh in your mind, that the Affordable Care Act threatens to harm our members by dismantling multiemployer health plans, and you said you didn't agree with that—and again, that is from the IBEW workers—I apologize for my throat. I have been fighting this croup for a week.

In my questioning, I would like to focus on the private insurance market reforms enacted under Obamacare and the effect they are having on dozens of businesses across the State of Missouri. Since 2006, the Missouri Association of Manufacturers has operated two healthcare consortiums, commonly referred to as multiple employer welfare arrangements. These groups now consist of 57 midsize employers that provide good, affordable health coverage to over 2,500 families that live in the State. Final rules relating to Obamacare's market reforms were issued in February of this year and state that in the case of the Missouri manufacturers healthcare consortiums any employer with fewer than 50 employees will be subject to strict new rules under the group market.

Eighty-one percent of employers covered under these consortiums have fewer than 50 employees. And this ruling will result in breaking apart their current arrangements and end the unique benefits and protections afforded to their employees. As President Obama promised years ago to these families, if they like their current healthcare coverage and want to keep it, they can. But sadly, it appears that that is not going to be the case.

While my staff attempts to get a final determination out of your agency on the future viability of these health plans, I would like to ask you some questions directly, yes or no, if you would, please.

Do you believe that these thousands of employees who do not want to lose their current coverage should be allowed to keep it? Yes or no?

Ms. TAVENNER. I would have to understand some of the details around this. I am not familiar with this, but I am happy to sit down with you and go through it, or with your staff.

Mr. LONG. OK. Well, it is a group of manufacturers, and maybe one has got seven employees and one——

Ms. TAVENNER. No, I understand that. But I don't know what their current coverage is. You know, I don't know how much it costs——

Mr. LONG. Well, they have been told that they can no longer do this consortium thing if they are under 50. I mean, the point is——

Ms. TAVENNER. They have not been told that by me. I am happy to sit down with them and review it, but I can't answer——

Mr. LONG. They would love to talk to you, and we will set that up. And is your agency dealing with similar multiemployer arrangements across the Nation and also effectively forcing them to end their current health benefit plan? You haven't heard of this?

Ms. TAVENNER. I cannot answer that yes or no. I am happy to deal with this on a case-by-case basis.

Mr. LONG. OK. But you don't know if similar multiemployer arrangements have been—you don't have anybody come to you and say, hey, we have got a group of different employers and they are not going to be able to keep their coverage?

Ms. TAVENNER. I have not had anyone come to me. But that doesn't mean it doesn't exist.

Mr. LONG. OK. That is my question. OK. Yes, OK.

And then once these new rules do eventually break up Missouri's healthcare consortiums, where would you suggest these employers and families go for similar affordable comprehensive coverage?

Ms. TAVENNER. Once again, I would have to sit down with them and see what——

Mr. LONG. I will get you with those people. And I appreciate it. And I know I am over my time, but earlier you said that these exchanges were going to be affordable, I believe you said, and a lot of people were going to be saving a lot of money on the exchanges. Is that accurate?

Ms. TAVENNER. Yes, I do believe that people will save money.

Mr. LONG. OK. If you would——

Mrs. BLACKBURN. The gentleman's time has expired.

Mr. LONG. OK. Thank you.

Mrs. BLACKBURN. Ms. Ellmers, 5 minutes.

Mrs. ELLMERS. Thank you, Madam Chairman.

And thank you, Administrator Tavenner, for being with us today. In your opening statement you had mentioned your previous——

Ms. TAVENNER. Yes, I saw your background as well.

Mrs. ELLMERS [continuing]. As nursing, and also as a hospital administrator.

Ms. TAVENNER. Yes.

Mrs. ELLMERS. Which leads me to some of my questioning today. I would like to go back to some of the discussion that was had by a couple of my colleagues. After the Treasury had come out with the employer reporting requirements being delayed for a year, you were asked by a couple of my colleagues, you know, did you express concern that the integrity of the employer verification system would be compromised? And you indicated no, that you had not done that after the delay was implemented. Is that correct?

Ms. TAVENNER. That is correct.

Mrs. ELLMERS. OK. Are you aware that you have previously issued a rule, on January 22nd, 2013, that stated that you—and I am quoting—"reporting under section 6055 and 6056 of the code," that is the employer mandate, "could greatly contribute to the integrity of the employer verification into the future"?

Ms. TAVENNER. I am happy to take a look at that.

Mrs. ELLMERS. OK. So yes or no, you are going to take a look at it?

Ms. TAVENNER. I am not doing a yes or no.

Mrs. ELLMERS. OK. Because I have that here as fact.

Ms. TAVENNER. I am happy to take a look at it.

Mrs. ELLMERS. OK. So you are not going to indicate whether that is true or that is not true?

Ms. TAVENNER. No, I would have to pull what I have done, take a look at it, and I am happy to verify that——

Mrs. ELLMERS. OK. So you can't comment on a rule that you put forward?

Ms. TAVENNER. I put a lot of rules forward, as you know.

Mrs. ELLMERS. OK. Well, we would like that for the record for committee, please. Thank you.

Ms. TAVENNER. I am happy to do that.

[The information appears at the conclusion of the hearing.]

Mrs. ELLMERS. OK. The next thing is the asset verification. Now, one thing I would like to clarify is CMS essentially is, you know, the governing body or the agency that is going to make sure that

the coverage, the exchanges, that Medicaid, you know, will be implemented, and that you are overseeing that, correct?

Ms. TAVENNER. Yes.

Mrs. ELLMERS. Yes. So when we are talking about HHS, HHS is actually over you, and essentially the decisions that they are making at that level will affect you, but not necessarily in a direct fashion, but almost in an indirect fashion.

Ms. TAVENNER. I usually am part of the senior management team of HHS.

Mrs. ELLMERS. OK. OK. Great. So my question for you is, do you agree that because the asset verification is also going to be kind of put aside and we are going to be on an honor system, that this can contribute to fraud and abuse? That individuals who are going to the exchanges would possibly put forward information that they could be mistaken about or that they just feel that they are putting in information so that they can get a subsidy?

Ms. TAVENNER. Are you talking about income verification?

Mrs. ELLMERS. I am talking about income verification and insurance verification. By delaying this, do you believe that that could contribute to fraud and abuse?

Ms. TAVENNER. No.

Mrs. ELLMERS. OK. So you said no. OK. Let's stop there. If the answer is no——

Ms. TAVENNER. No, you are asking about—are you asking about income verification? I am confused.

Mrs. ELLMERS. OK. Income verification or insurance verification by an employer. Either one or both.

Ms. TAVENNER. OK. On the front end, remember we are doing 100 percent review of this, so if you ask me——

Mrs. ELLMERS. OK. On the front end. But that is put aside. The verification process will be on the back end, correct?

Ms. TAVENNER. Not for income, no, it is on the front end.

Mrs. ELLMERS. OK. So——

Ms. TAVENNER. That is why I think I am confused with what your question is.

Mrs. ELLMERS. OK. So the asset verification, so the understanding that we all have——

Ms. TAVENNER. Do you mean employer verification?

Mrs. ELLMERS. No, I am not talking about employer verification.

Ms. TAVENNER. OK.

Mrs. ELLMERS. I am talking about the rule that came out by HHS a couple of days after. That is what I am talking about. OK. So let's just stop there.

Ms. TAVENNER. It is income verification, I think.

Mrs. ELLMERS. OK. We are talking about income verification.

Mrs. TAVENNER. I think you are confusing it with asset. We don't look at individual assets.

Mrs. ELLMERS. OK. Assets, income, you know, money.

Ms. TAVENNER. Income is what we look at, right?

Mrs. ELLMERS. Money. OK. Income verification. Do you or do you not believe that that could contribute to the possibility of someone fraudulently putting information forward?

Ms. TAVENNER. I don't know. I think there is a very small world of individual——

Mrs. ELLMERS. OK. Well, let's move on. Now, I do want——

Ms. TAVENNER. I really didn't answer that, right?

Mrs. ELLMERS. Well, but you are not answering.

Ms. TAVENNER. I am trying.

Mrs. ELLMERS. In your opening statement you discussed—and I am with you, I want to see as many people as we can get coverage, insurance coverage, affordable insurance coverage. But isn't that really your goal? I mean, you know, as far as income verification, whether there is insurance being provided, isn't your goal really to just get as many people on this exchange as possible so that it prevents the possibility of moving forward for the actual verification and actual removal of the subsidy or having to pay back that money, because of your background?

Ms. TAVENNER. Once again, we are doing 100 percent review of income verification, so I don't understand your question.

Mrs. ELLMERS. OK. So you are saying that up front there will be 100 percent income verification.

Ms. TAVENNER. Correct.

Mrs. ELLMERS. OK. And I would like for you to provide to the committee that information as well, because that is not our understanding.

Ms. TAVENNER. That is fine.

[The information appears at the conclusion of the hearing.]

Mrs. ELLMERS. Thank you.

And, Madam Chairman, I yield back the remainder of my time.

Mrs. BLACKBURN. Mr. Harper, 5 minutes.

Mr. HARPER. Thank you, Madam Chair.

And thank you, Ms. Tavenner, for being here and for your testimony. And I also would like to tell you how much I appreciate your personal involvement with compounding pharmacists in Mississippi and our discussions with you towards our shared goal of maintaining access to necessary pain medication for some of Medicare's most vulnerable beneficiaries.

It was recently announced that the administration would be delaying the law's employer mandate until 2015. One of the reasons cited by the administration for delaying was to provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees, thereby decreasing the amount of uncompensated care that hospitals must provide.

As you are aware, hospitals, which certainly are large employers and a crucial component of our medical landscape, are also faced with navigating a multitude of regulations. Delaying DSH cuts would grant these medical providers the same stability recently afforded other employers. If the mandate to provide new coverage is to be delayed, then so should any corresponding cuts to reimbursements for uncompensated care.

In light of this decision, is the administration taking steps to delay the cuts to the DSH payments, to the disproportionate share hospital payments?

Ms. TAVENNER. In the President's proposed budget for 2014 there is a request for delay of Medicaid DSH cuts for 1 year.

Mr. HARPER. So you would agree that the administration has that authority to do that?

Ms. TAVENNER. It is in the President's proposed budget for Medicaid, yes.

Mr. HARPER. Thank you.

Just last week I received an email from a gentleman in Ridgeland, Mississippi, in my district. Forrest Collier is his name. And he noted that his family's healthcare premiums increased from roughly $8,000 last year to nearly $19,000 this year. That is an incredible jump. So we have a family in my home State that has seen their premiums jump from $8,000 to $19,000 a year.

Not only does this limit Forrest's ability to provide for his family, but this rate shock also has kept the Colliers from doing the things that they enjoy most. In Mr. Collier's words, he said in his email, "Obamacare is a train wreck and is having a huge impact on working families." You know, he is right, and this is not what Mississippi families were promised.

Ms. TAVENNER. So I actually think, obviously, Obamacare, from his perspective, rates have not gone into effect yet. But what he is experiencing is what is in my written testimony, is the last decade of double-digit, triple-digit increases. That is what the Affordable Care Act is designed to correct.

Mr. HARPER. And if I may say this, he is not the first person, he wasn't the one who coined the term train wreck. Actually, there have been Democratic Senators who voted for it who are declaring this a train wreck themselves. But the American people were promised time and again that working families would see a $2,500 drop in premiums. And in your testimony, and you claim, and I paraphrase, that there is growing evidence that these reforms are working for the entire system, keeping costs low for consumers shopping for coverage in the private health insurance market.

How can the administration make this claim when Mr. Collier's testimonial proves otherwise, the other questions that we have had here? And interesting, it appears that the IRS chief Danny Werfel—not the quarterback from Florida, but the current IRS chief—said that he wanted to keep his healthcare plan and not switch to Obamacare. And so I just see that that has been reported. And of course the National Treasury Employees Union has done the form letter. And so, you know, I know you have said——

Ms. TAVENNER. So going back to your first question about costs, if you look at Medicare cost trends, it is at an all-time low. Medicaid is the same. And if you talk to large employers, as I have, particularly in Georgia, they will tell you that their cost trend is at the lowest.

Mr. HARPER. And that is so contrary to what we are hearing in my State and from others that we have had. And I know you have talked to people all over the country. I have talked to people all over the State of Mississippi, more than even just my district, small and large as well. And the trend is greatly increasing. And we are also having people——

Ms. TAVENNER. So I think that in the individual——

Mr. HARPER. I am going to give you a chance, OK?

Ms. TAVENNER. OK.

Mr. HARPER. But let me say this. And I do, again, appreciate your hospitality on our phone calls. But I do want to say this. I have had numerous people, employers and the employees, who said

they have gone to part-time hours. So I think that your statement earlier in your testimony you might want to take another look at, because that is contrary to what we are seeing. And I thank you for your time today. Thank you.

And I yield back.

Mrs. BLACKBURN. Mr. Kinzinger, 5 minutes.

Mr. KINZINGER. Thank you, Madam Chair.

And again, thank you for being here. I am sure you are enjoying every moment of this. But we love having you in front of us. And I appreciate your service to your country and being here. I don't know why I am getting echo here. It is probably you.

Mr. GRIFFITH. That is what I was thinking. It must be Pompeo.

Mr. KINZINGER. I will see if that one works. All right. This is better.

I wanted to dovetail on what I heard a little earlier. I have not really had any small business tell me that this was going to work out for them. In fact, all we have been hearing, and I talk to small businesses and regular big businesses all the time in my district, and we consistently hear about their concern about this, what it is going to do. In fact, a lot of folks have said that they have held off on hiring people because they don't know what this is going to mean.

So I don't know, if you haven't heard from it, maybe we could set up a hotline or something where people can call, or an email address where they can tell their stories, because I guarantee you——

Ms. TAVENNER. So I am happy to work with your staff and set up as many conversations as you would like.

Mr. KINZINGER. That would be wonderful. Let me just ask you, I just have a few quick, hopefully, questions. Do you know how many agencies are involved with implementing the healthcare law?

Ms. TAVENNER. How many agencies?

Mr. KINZINGER. Yes.

Ms. TAVENNER. I wouldn't know exact numbers. There are obviously multiple. We are at least working with eight other agencies.

Mr. KINZINGER. How many? What would you estimate? I mean, if you had to say.

Ms. TAVENNER. I am happy to get that information for you. I wouldn't make a guess.

[The information appears at the conclusion of the hearing.]

Mr. KINZINGER. OK. And how often are you in contact with the other agencies implementing this healthcare law? So who are some of the other ones you are in contact with? How often are you talking to them?

Ms. TAVENNER. So I think for our staff, because of the testing of systems, they are in frequent contact with other agencies.

Mr. KINZINGER. Is there, like, a regular interagency meeting on the implementation that happens?

Ms. TAVENNER. Yes.

Mr. KINZINGER. How often is that?

Ms. TAVENNER. I actually think it is monthly.

Mr. KINZINGER. OK.

Ms. TAVENNER. But I can get back with you with the details.

[The information appears at the conclusion of the hearing.]

Mr. KINZINGER. Is there a deputies or other regular kind of meeting convened by the White House staff on implementation?

Ms. TAVENNER. I don't know the answer to that, but I can get it for you.

Mr. KINZINGER. OK. So you don't know if the White House is——

Ms. TAVENNER. I am sure the White House is meeting. I am just saying I can't give you specifics. I would rather not speculate as I am sitting here in front of the committee. So I am happy to get you that information.

[The information appears at the conclusion of the hearing.]

Mr. KINZINGER. OK. And as the head of CMS, how are you briefed on the implementation of the law as it is being implemented?

Ms. TAVENNER. How am I briefed?

Mr. KINZINGER. Yes, how do they brief you?

Ms. TAVENNER. Oh, we talk about this daily, as you might imagine.

Mr. KINZINGER. So is it like an official brief, or is it kind of a spitballing, like here is what is going on?

Ms. TAVENNER. We have weekly operations meetings. We have informal briefings every day, as you might imagine, with 61 days left.

Mr. KINZINGER. Sure. Do you guys run a daily implementation meeting for the agency?

Ms. TAVENNER. Pretty much.

Mr. KINZINGER. Do you receive written updates, too?

Ms. TAVENNER. Written updates not so much, because you imagine every day it is much easier do that in an oral.

Mr. KINZINGER. So you get no written updates?

Ms. TAVENNER. We have written updates, yes.

Mr. KINZINGER. Would you mind at some point maybe submitting some of those for the record?

Ms. TAVENNER. I don't mind. I think that we have submitted them in the past, and we are happy to do so.

[The information appears at the conclusion of the hearing.]

Mr. KINZINGER. Good. Thank you. And does the HHS Office of Health Reform run regular meetings on implementation? And if so, how often?

Ms. TAVENNER. So the Office of Health Reform has been more on the policy end, so not so much daily implementation. They certainly participate in some of our meetings.

Mr. KINZINGER. OK. Quickly, again, how much did you say the healthcare law was going to cost to implement? What is the latest estimates that you know?

Ms. TAVENNER. I think the specific request that I had was how much had we spent on the hub, and that is $400 million.

Mr. KINZINGER. So does that number include the money spent on advertising and implementation?

Ms. TAVENNER. It does not.

Mr. KINZINGER. Do you know about how much that is?

Ms. TAVENNER. I am happy to get you our budget.

Mr. KINZINGER. But you don't have that on the top of your head, how much is being spent on——

Ms. TAVENNER. Well, I mean, I can start down the path. We are going to award like 50-some million in navigator grants. We have enrollment and eligibility contractors, which are a couple hundred million. I mean, I can go through the list, but I just think it is easier to supply you that on paper. I pretty much have all those memorized in my head. I just would like to get them accurate.

Mr. KINZINGER. And I got it. And I appreciate you submitting that on paper. But this is a public hearing where, you know, obviously, people want to be updated on how much their law is costing.

Ms. TAVENNER. Yes.

Mr. KINZINGER. So give me like just kind of a big total number. I don't need all the details——

Ms. TAVENNER. So a big total number for our spend, all inclusive of everything that we are doing?

Mr. KINZINGER. Yes, advertising and outreach and all that.

Ms. TAVENNER. Right. Would be probably about $1.3 billion.

Mr. KINZINGER. OK. All right. And where is that money coming from?

Ms. TAVENNER. Well, obviously, part of it is from the Affordable Care Act, the billion, and then there has been some secretarial transfer of funding, and then some use of the prevention fund.

[The information appears at the conclusion of the hearing.]

Mr. KINZINGER. OK. All right. Well, that is all of my questions. And I thank you again for your time and being here.

And I yield back.

Ms. TAVENNER. Thank you.

Mrs. BLACKBURN. Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you very much, Madam Chair. I appreciate it. We are getting a little echo again. OK.

Thank you for being here. I appreciate it very much. Thanks for being here all these hours.

I have a question, Administrator Tavenner. We are beginning to hear from States about their increasing concerns with the new eligibility system and the new requirements for determining Medicaid eligibility. These concerns are coming from States that are expansion States, but also non-expansion States like my State of Florida. Under the President's healthcare law, Medicaid eligibility will now follow a uniform income verification standard of modified adjusted gross income methodology. The question: Is CMS confident that all States will be ready to transition their existing eligibility policies to the new eligibility standard on October 1st, about 40 business days from now? That is the first question.

Ms. TAVENNER. So what we are doing with States, we have States in varying degrees of readiness based on their systems and the changes in their systems. So we have some that will be fully automated and ready to go, some that have workarounds, but everyone will be able to move to the new——

Mr. BILIRAKIS. Specifically, as of today, how many States will be absolutely ready to implement these changes on October 1st?

Ms. TAVENNER. That is a different question. You are asking me about the marketplaces. All States are ready to implement the marketplaces.

Mr. BILIRAKIS. All States will be ready.

Ms. TAVENNER. On October 1st, yes.

Mr. BILIRAKIS. What protections are in place for States that are forced to make these quick Medicaid eligibility decisions? What protections are there? Has CMS done any internal projections and calculations of the cost from improperly accepting or denying individuals from Medicaid under the new eligibility requirements? But, yes, first answer me what protections are in place to protect States.

Ms. TAVENNER. So I don't know that I look at it so much for protections. What we do is we have a team that is dedicated to working with the States to help them implement their programs and to help them have systems in place so that we can make sure that individuals are adequately being screened for Medicaid if they are eligible. Because each State is different. So we have individual teams working with each State to help them prepare.

Mr. BILIRAKIS. OK. Then it is my understanding that there have been a total of $20 billion in improper—Medicaid eligibility review has resulted in an average of $20 billion overpayments each year on the average. Can you share any projections with this committee with regard to that?

Ms. TAVENNER. You are talking about improper payments. And, yes, we can get you that information.

Mr. BILIRAKIS. You can get that information to me?

Ms. TAVENNER. Of course.

Mr. BILIRAKIS. You don't have that available now?

Ms. TAVENNER. It is public, and I will be happy to get it to you.

[The information appears at the conclusion of the hearing.]

Mr. BILIRAKIS. OK. Are you working on a contingency plan with States in the event that their systems are not ready by October 1st?

Ms. TAVENNER. That is what I am talking about with workarounds, mitigation, call it whatever you want. But yes, we have——

Mr. BILIRAKIS. But you are working on a contingency plan?

Ms. TAVENNER. Yes. Of course. As any large business.

Mr. BILIRAKIS. OK. All right. Very good.

Madam Chair, I ask unanimous consent to enter into the record two items. The first is a letter from the Florida Department of Children and Families, where they talked about the challenges of the new Medicaid eligibility rules and the need for flexibility meeting the October deadline. And then the second one is a news story from Reuters about how the insurance rates in Florida and in Georgia are going to rise significantly. I ask unanimous consent.

Mrs. BLACKBURN. Without objection, so ordered.

[The information follows:]

State of Florida
Department of Children and Families

MYFLFAMILIES.COM

Rick Scott
Governor

David E. Wilkins
Secretary

February 21, 2013

Stephanie Kaminsky, Senior Policy Advisor
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Submitted electronically to: www.regulations.gov
Attention: CMS-2334-P

Dear Ms. Kaminsky:

Thank you for the opportunity to comment on the January 22, 2013 proposed rule implementing provisions of the Affordable Care Act (ACA) for Medicaid and Children's Health Insurance Program (CHIP) eligibility. Florida like many other states is particularly concerned about the proposed requirements under §435.1205 that Medicaid and CHIP meet an October 1, 2013 schedule for the following:

- Accepting single streamlined applications for all Insurance Affordability Programs
- Determining eligibility using the new Modified Adjusted Gross Income (MAGI) related rules, while also determining eligibility using the 2013 rules
- Transferring electronic accounts and applications to other programs
- Receiving electronic accounts from other programs.

As you know, the challenges in implementing the provisions of the ACA are formidable. Issues related to system development, integration and federal system testing requirements, in light of pending policy guidance, makes achieving compliance with the January 1, 2014 deadline a challenge. This, along with the highly complex policy implementation needed as a result of substantial Medicaid Program changes from the ACA, places an unreasonable burden on states to be able to meet the proposed October 1, 2013 timeframe. The Department strongly recommends that the regulation enforce only the 2014 deadline. This would enable Florida and other states to continue to work in partnership with CMS and vendors to achieve not only compliance, but also assure an effective and quality transition to these changes, which as we all know will greatly impact how services are delivered to applicants and recipients.

Your consideration of this important provision and a reasonable time frame for compliance is appreciated. The Department of Children and Families is working diligently to achieve compliance and recognizes the importance of coordination across insurance affordability programs. Please contact me at (850) 487-1111 if you have any questions or need additional information.

Sincerely,

David E. Wilkins
Secretary

REUTERS

» Print

Florida, Georgia say insurance rates to spike under Obamacare

Tue, Jul 30 2013

By Caroline Humer

(Reuters) - Florida and Georgia, two states where politicians oppose U.S. President Barack Obama's healthcare law, said on Tuesday that insurance rates for individuals would rise sharply in 2014 under the reform.

The remarks are part of an increasingly polarized debate over whether "Obamacare" will prove affordable for millions of uninsured Americans when new health plans become available on state-based exchanges as of October 1.

Several states that have embraced the healthcare reform have shown residents how the law will reduce insurance costs, while those that have opposed its implementation are beginning to present it as a more expensive prospect for consumers.

The figures released do not factor in substantial government subsidies that will be available to many consumers based on household income, which will offset their actual out-of-pocket expenses. The government is planning for 7 million people to sign up for the new health plans that take effect in 2014.

Georgia said that insurance premiums for a 25-year-old male currently in a high-deductible plan would rise up to 198 percent in 2014 and rates for many others could rise by 20 percent to 100 percent. Georgia asked the U.S. Department of Health and Human Services to delay a Wednesday deadline for a final rate submission from the state.

The department said it was working with the all states to meet deadlines and reviewing Georgia's request.

Florida's office of insurance regulation said on Tuesday that rates for individuals will rise roughly 30 to 40 percent next year. Florida compared a 2014 mid-tier silver plan with a fictional 2013 plan that was created to cover the same 70 percent of the health care expenses that a silver plan will. Current plans may cost less than the fictional plan, but they also provide fewer benefits.

"If you take a straight average you get a distortion because you don't have the same benefits," Florida Insurance Commissioner Kevin McCarty said.

Indiana's department of insurance last week said that insurance costs to individuals under the Affordable Care Act would rise 72 percent. Unlike other states disclosing insurance plan prices, Indiana factored in not only premium rates, but also the costs of other insurance components like co-pays and prescriptions.

"These announcements from states have almost been a Rorschach test of how they view Obamacare," said Larry Levitt, vice president of special projects for the Kaiser Family Foundation.

"Consumers are hearing a welcoming message from states that are participating in implementing the law ... and that could absolutely have an effect on how many people enroll," he said. "The reverse is also true" for states that are warning consumers that prices will be high, he said.

California, one of the states that has most enthusiastically prepared for Obamacare, kicked off the debate in May when it said costs for products for individuals would fall for a 40-year-old nonsmoker by up to 29 percent compared to similar products. New York said earlier this month that average rates would drop by more than 50 percent.

The U.S. Department of Health and Human Services earlier this month said in 11 states that it studied were 18 percent lower than expectations, based on Congressional Budget Office Estimates, and that this would likely be the case nationally.

"We are confident that Florida's premiums will be affordable, and that consumers will have multiple options in a competitive and transparent marketplace," a senior administration official said in response to a Reuters query about the rate comments. "Without releasing the premiums, the statistics released today don't provide consumers with any information on what they will actually pay in the marketplace."

(Additional reporting by David Morgan in Washington and Sharon Begley in New York; Editing by Michele Gershberg and Lisa Shumaker)

Mr. BILIRAKIS. OK. Thank you very much. Appreciate it. I yield back.

Mrs. BLACKBURN. The gentleman yields——

Mr. BILIRAKIS. Oh, I would like to yield the remaining time to Dr. Cassidy, please.

Mrs. BLACKBURN. Without objection.

Dr. Cassidy.

Mr. BILIRAKIS. Thank you.

Mr. CASSIDY. Thank you.

Hey, Ms. Tavenner, I am sorry I couldn't give you time to answer last time. There is so much to get through. But my friend yielded to me.

You mentioned that there is going to be 100 percent attestation for income. But I think we have up there, and again my bad eyes won't tell me this, but I have it on my computer, that you had issued a statement earlier. If you look at the second paragraph up there, this is in the Federal Register, "To provide relief to State-based exchanges planning to rely upon this attestation service, we are delaying the date by which the exchange must implement sample-based review, not 100 percent." And it goes on to say, without further verification, instead of following the procedure in 155.320, et cetera, et cetera.

So you are providing relief to State-based exchanges, and the exchange may accept the applicant's attestation regarding enrollment in the eligible employer-sponsored plan and eligibility for the qualifying coverage and eligible employer-sponsored plan. And that just seems different than what you said, that there is going to be 100 percent——

Ms. TAVENNER. Remember, I was talking about 100 percent review for the Federal exchanges, so for 34 States.

Mr. CASSIDY. So California is the biggest State in the Union, obviously. So you will not have attestation for the biggest State in the Nation. You are giving them relief.

Ms. TAVENNER. I will get you how they are individually working it for each of the State-based exchanges. That is the easiest way to explain it.

[The information appears at the conclusion of the hearing.]

Mr. CASSIDY. I understand that. But just for the record, you will not be doing, you are not requiring attestation——

Ms. TAVENNER. That is correct.

Mr. CASSIDY [continuing]. For California——

Ms. TAVENNER. That is correct.

Mr. CASSIDY [continuing]. Which is the biggest State. So I am sorry, I didn't realize that you were speaking only of the Federal plan earlier. I wish this was earlier in the hearing, because I am not sure our colleagues appreciated that either.

I yield back. Thank you.

Mrs. BLACKBURN. The gentleman yields back.

Mr. Pompeo, 5 minutes.

Mr. POMPEO. Thank you, Madam Chairman.

A couple questions, I want to try and get yes or no answers. We haven't been very successful at getting yes or no answers today. I would sure appreciate if you would at least try.

You are involved in running test cases today with private insurers. Is that correct?

Ms. TAVENNER. Correct.

Mr. POMPEO. CMS is, not you. But CMS is involved.

Ms. TAVENNER. Yes.

Mr. POMPEO. What percentage of the exchange enrollment test cases you are running with these private insurers have been successfully passed?

Ms. TAVENNER. So I don't exactly know how to answer that question. All of them have been successfully passed. So you test——

Mr. POMPEO. So the answer is 100 percent.

Ms. TAVENNER. Yes, you test, you correct, you test, you correct, and you keep going. So we are about 80 percent complete on all of our testing throughout, OK? And the last 20 percent would be what you complete between now and October 1.

Mr. POMPEO. Sounds good. I want to ask you whether you agree with—you talked about California being a model that is successful to where you are seeing rates go down. Is that right?

Ms. TAVENNER. The rates, yes.

Mr. POMPEO. I want to read you a statement that is in Governor Brown—noted conservative—Governor Brown's budget, where he says, "Large rate increases in the individual insurance market are likely at the outset due to the requirement to offer coverage to all individuals." Is he just wrong?

Ms. TAVENNER. I am not——

Mr. POMPEO. No, but he made a statement. It conflicts apparently with what you said. Is Governor Brown wrong?

Ms. TAVENNER. I am going to say we were pleased with the rates, and we have seen a decrease, and so far what we have seen in terms of published rates, it is actually running about 18 percent below CBO estimates.

Mr. POMPEO. I asked that question, importantly today, we had someone on the other side say that we are badgering you and suggested this was conservatives who didn't like the Affordable Care Act. Governor Brown in California, the State that you all hold up as the model for what the Affordable Care Act is doing, in his budget, where he has got to actually balance, suggests otherwise. And so I suppose time will tell whether you, Ms. Tavenner, are correct or Governor Brown is correct.

CBO says $12 billion is the cost from the delay of the employer mandate. Do you agree with that data?

Ms. TAVENNER. I saw the CBO estimate.

Mr. POMPEO. Do you agree with the estimate? Do you believe that is correct?

Ms. TAVENNER. I mean, I would have no way——

Mr. POMPEO. But you are responsible for the implementation of this. You have to have a view. When you made the decisions, you have to have a view.

Ms. TAVENNER. So first of all, I will remind you, the employer mandate sits with Treasury. Second, I would have every reason to believe CBO estimates.

Mr. POMPEO. Do you know how 1 year was chosen for the delay? Why not 11 months and why not 13 months? Do you know how 1 year was chosen? Did you have input into that?

Ms. TAVENNER. I did not have input into that.

Mr. POMPEO. So you don't know why it was chosen. Do you think there is any risk that it will be delayed again?

Ms. TAVENNER. I don't have an answer for that either.

Mr. POMPEO. So you think there is some chance that it will be. You didn't know about it the first time.

Ms. TAVENNER. That is not what I said, but OK.

Mr. POMPEO. No, my question is, do you think there is any chance it will be extended one more time?

Ms. TAVENNER. I don't see any reason that it would be.

Mr. POMPEO. No reason. So you think the probability is zero?

Ms. TAVENNER. Yes, I think the probability is zero.

Mr. POMPEO. All right. Time will tell.

You have a series of folks that have talked to you about things today, you have mostly excused them as anecdote, you said they were isolated. You have talked about folks with businesses who were going to get rid of their coverage.

I have a letter that I would like to submit that came from a doctor in Kansas, Madam Chairman, I would like to submit it for the record.

Mrs. BLACKBURN. Without objection.

[The information follows:]

Dear Congressman Pompeo

I went through school with the promise that if I applied myself, put in the time, and performed at my best, then I could make an honest living that would afford my family the luxuries that I desired for them, and help humanity at the same time. I believed the American Dream; that perseverance, hard work, and sacrifice are a recipe for success in this country and that if you apply those principles, you can make something of yourself; you can prosper.

I graduated school in 2004 and began practicing as a Doctor in the State of Kansas. My burden was large, with student loans totaling above $200,000. Add to that a mortgage and a business loan, and pretty soon I was a half a million dollars in debt, but that was OK. It was the price of achievement, and I knew that if I applied myself, the investment would be more than worth the return.

And for the first few years, it was. I was able to generate a decent six figure income and my family was able to enjoy the fruits of almost ten years of grueling education and sacrifice. The future looked bright and prosperous. I come from a large family of health care practitioners and we were all offering quality healthcare at reasonable rates, and we were successful.

After Obamacare passed, no longer was I the deciding factor in the care of my patients. Now their care was determined by auditors and algorithms and hypothetical standards of care based on averages, or textbook cases that did not actually exist in the real world.

Obamacare will harm patients by affecting the quality of care. When you create dependency and entitlement, you then decrease the amount - if any - a citizen is willing to pay out-of-pocket for services. So let's say that the average doctor graduates school with between $150,000 to $250,000 in student loans. Malpractice insurance will run them another $6,000 - $34,0000 a year, depending on their specialty. If they start their own practice, you can tack on another $150,000 to $300,000 in business loans (and that is conservative). Medical school lasts on average, about eleven years, with eight years of classroom and then one year of internship and two years of residency. The vast majority of doctors get into this field because of an intense desire to help their fellow citizen and to achieve all that they can. But when they cannot make enough money to offset their cost-of-living, pay off their loans in a timely manner, and then take their kids to Disneyland every now and then, they will move into a field in which they can succeed. Why go to all of this trouble in order to make less than they could in another field? In short, we will lose the best and brightest.

Now it may be easy to dismiss my story as just one story out there. But I am not the only one in this predicament. Everyone in my family is struggling right now. They all are fighting hard, just to keep the doors open. At this point, it is not about thriving as much as surviving.

One of the independent contracting Doctors in my clinic has been working with me since April and is still unable to provide the common basic necessities for his family of five, without some kind of assistance. Unfortunately, it continues to be more difficult to make a living as a doctor. I am afraid that it will not get any better.

In closing, I am concerned. I am concerned about my patients. I am concerned about my employees. I am concerned about my industry. I am concerned about America. I still believe that the American Dream is more reality than dream, but sometimes I lose faith for a bit. We want the best care in our country. We want the greatest health care system on the planet. That will not happen if the achievers are penalized. I do not want to diminish all government aid, but Obamacare will be a dismal failure, and if the belt gets any tighter, my blood will be cut off.

Thank you for considering this and reading my story,

A Concerned Kansas Doctor

Mr. POMPEO. And he talks about the fact that it will be more difficult for him to run his practice under the Affordable Care Act and that he thinks throughout Kansas there will be less access as a result of that. Is he right about that?

Ms. TAVENNER. If you are asking are we having good physician participation on the exchanges, the answer would be yes. We still have it in Medicare and Medicaid, so we are not seeing less access. We have always had pockets of access and coverage that we have been worried about across the country.

Mr. POMPEO. So what should I tell him? Should I tell him to stop worrying about it, or that he is wrong, or that Ms. Tavenner assures him he is going to be OK? Which of those three responses? Because I have got to respond——

Ms. TAVENNER. First of all, you can tell him he can talk to me. OK?

Mr. POMPEO. All right. I am confident he will like to speak to you.

Ms. TAVENNER. But second, what I would tell him is that we actively work to make sure that we have access in Medicare, Medicaid, and in the exchanges, and that we are also actively promoting training. Because we understand as you insure more people you are going to need more primary care physicians. And that was also part of the funding of the Affordable Care Act.

Mr. POMPEO. So you are assuring me that we are going to continue, that we are not going to see large numbers of doctors have the same view that he is concerned with. Is that right?

Ms. TAVENNER. That is right.

Mr. POMPEO. All right. Great. I hope that you are right.

Last, this should be easy for you to answer yes or no. The President said, if you like what you have you can keep it. Is that true?

Ms. TAVENNER. Yes, it is true for large employers.

Mr. POMPEO. No, no, he didn't put the caveat for large employers. You just added a caveat. He said, if you like what you have you can keep it. Is that true?

Ms. TAVENNER. It is true, and that is under the assumption that your insurance is true insurance, that it provides coverage. Obviously, we have put some protections in place against insurance that is not true insurance where individuals are paying monthly fees and then go in to find out, oops, their hospitalization is not covered, or oops, their cancer care is not covered. So we put some protections in place around that.

Mr. POMPEO. Madam Chair, I yield back.

Mrs. BLACKBURN. The gentleman yields back.

Mr. Griffith, 5 minutes.

Mr. GRIFFITH. Thank you, Madam Chair.

Thank you for being with us. I would reference you first to a Roanoke Times article that is actually a reprint or same day as the Richmond Times-Dispatch about Virginia, our home State. And it says that while most localities in Virginia have three or four plans available, talking about plans that have been approved by the Virginia insurance folks to be in the insurance exchange, while most localities in Virginia will have three or four plans available, several localities in southwest Virginia will have only one plan offered.

That certainly wasn't what was contemplated when the bill was passed, was it, that there would be areas that would only have one plan, one choice? That wasn't contemplated? Yes or no? Because we only have limited time.

Ms. TAVENNER. Congressman Griffith, you know as well as I do there has only been a history of one insurance plan in southwest Virginia. It will take time to introduce new plans to rural markets, and that is an example of a rural market.

Mr. GRIFFITH. And I was surprised that you have indicated throughout this that you have heard of isolated incidences where people were laying off or cutting back hours significantly in light of the fact that the Commonwealth of Virginia itself, 7,500, according to the Richmond Times-Dispatch, Washington Post article indicates that maybe as many as 10,000 Virginia, Commonwealth of Virginia employees are having their hours cut. You wouldn't consider the Commonwealth of Virginia as an isolated incident, would you?

Ms. TAVENNER. I have heard of the State of Virginia, yes, and that it would be one of the ones of the isolated incidents I have seen.

Mr. GRIFFITH. So up to 10,000 employees that are being impacted are isolated?

Ms. TAVENNER. And I will remind you it is up to 10,000.

Mr. GRIFFITH. Let me refer——

Ms. TAVENNER. But I don't think they have taken any action yet. In fact——

Mr. GRIFFITH. Oh, yes, they have, ma'am. It is the law of the Commonwealth of Virginia as of July 1. It would have been nice, if the administration was going to delay that, if they had let folks know before then, because they notified after the law took effect in Virginia. And so those employees have already been impacted.

And furthermore, it is not just the Commonwealth of Virginia. I have counties in southwest Virginia that also have made some decisions in that regard. And according to a Washington Post article of July 24th, talking about the Virginia situation, that is not isolated. They indicate there that a company called Mercer in that article, which I would recommend to you, has done a survey, and estimated that 12 percent of the employers in the United States plan to lay off workers or cut their hours back. This is where we get frustrated——

Ms. TAVENNER. And I can submit to you an equal number of studies that say quite the opposite.

Mr. GRIFFITH. OK. Well, the Commonwealth of Virginia is not a study, it is a fact.

Now, that being said, you indicated earlier that you are willing to talk. Because I have employers all over southwest Virginia that are concerned. And you indicated to Mr. Kinzinger that you would be happy to talk with those employers. Is that also true for my constituents?

Ms. TAVENNER. Absolutely.

Mr. GRIFFITH. Thank you very much. I do appreciate that, because it is a big concern. And I will tell you that, you know, we are hearing—I mean I have heard from one business that does deal with the service industry that they are struggling with what they

are going to do. But one of the things that they might be able to do would be to lay off about 12 or 13 employees on one shift that is their least productive shift. But if they laid that shift off they wouldn't be covered because they would have less than 50 employees. For those of us out in the field on a regular basis, and I know you have said you have been out there, but you are hearing something completely different from us.

Also, if I might ask this question. When does the Medicaid maintenance-of-effort expire for a State that has deferred to a federally facilitated exchange? Will you be issuing further guidance on the MOE, as the last guidance was issued before the Supreme Court decision?

Ms. TAVENNER. OK. So the exchange and MOE are two separate issues, right?

Mr. GRIFFITH. All right.

Ms. TAVENNER. But there is guidance out there on maintenance-of-effort. And I am happy to answer any of your questions.

Mr. GRIFFITH. When would that expire for a State that has deferred to the Federal exchange?

Ms. TAVENNER. I don't think it is related to the Federal exchange. And I don't think the MOE expires per se.

Mr. GRIFFITH. So you don't think it will ever expire?

Ms. TAVENNER. I am not sure what your question is.

Mr. GRIFFITH. I understand. All right. Well, will get that question to you so you can get us a question in writing back on that.

Ms. TAVENNER. That would be fine. If you can give me an example.

Mr. GRIFFITH. Yes. I also will tell you that one of the big concerns I have, because in those areas where we have limited health insurance coverage in southwest Virginia, we are also seeing some real stress on our small rural hospitals.

Ms. TAVENNER. Absolutely.

Mr. GRIFFITH. And I am very concerned. Some have already indicated they are laying off folks because they are concerned that they won't get enough patients in a particular practice area. And for some of my people that means in very critical areas of health care they are now looking to have to drive an hour and a half to 2 hours to get the care that they used to be able to get in their hometown. And the folks are saying that that is directly related to some of the aspects of Obamacare. Do you have time to comment on that?

Ms. TAVENNER. You know that I am very familiar with rural Virginia——

Mr. GRIFFITH. Yes, ma'am.

Ms. TAVENNER [continuing]. And issues of access. I think they were there before Obamacare.

Mr. GRIFFITH. They were there before Obamacare. Unfortunately, the stress from Obamacare is making them worse.

I appreciate it and yield back.

Mrs. BLACKBURN. The gentleman yields back.

And Mr. Long, I think you wanted 30 seconds to finish?

Mr. LONG. Thank you, Madam Chairwoman.

Earlier I had mentioned to you about the Missouri Association of Manufacturers. And my staff has informed me that they have been in contact with your people, your attorneys in particular.

Ms. TAVENNER. OK.

Mr. LONG. So Pete Stehouwer from my office is going to give you Rita Needham's phone number and email.

Ms. TAVENNER. Perfect.

Mr. LONG. And if you would promise me that you will get involved directly with her and talk to her. Because sometimes it gets at the staff level, through your attorneys, you might not be aware of it. But it is 25,000 families in Missouri. And I really appreciate it.

Ms. TAVENNER. I will do that.

Mr. LONG. Thank you. And thanks for your time here, our 3 hours and 20-some minutes we have been here. Thank you.

Ms. TAVENNER. And I am hoping we are near the end, because I do have some other work to do called 61 days.

Mrs. BLACKBURN. Well, and I do want to thank you. And I do want to thank all of our members who have been very patient today. And we thank you for your testimony. I would ask that all members remember that additional questions can be submitted for 10 days, that will be by August 15, the close of business.

Ms. Tavenner, we do ask that you respond very promptly to these because we are looking at an October 1 start.

And as you can hear, our constituents have questions. They are very valid. And on both sides of the aisle, there were questions for you. And they are things that are coming from constituents who are seeking answers and are not getting them. So we do thank you for that.

Without objection, this hearing is adjourned.

[Whereupon, at 1:25 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

August 22, 2013

The Honorable Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Tavenner:

Thank you for appearing before the Committee on Energy and Commerce on Thursday, August 1, 2013, to testify at the hearing entitled "PPACA Pulse Check."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Thursday, September 5, 2013. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Fred Upton
Chairman

cc: Henry A. Waxman, Ranking Member, Committee on Energy and Commerce

Attachments

Marilyn Tavenner's Response to Questions for the Record
"PPACA Pulse Check"
Before
Energy & Commerce Committee

August 1, 2013

Attachment 1—Additional Questions for the Record

The Honorable Joseph R. Pitts

1. **There has been concern voiced from the patient and provider communities that agency actions related to the ESRD Community, reflected in the FY2014 Proposed Physician Fee Schedule Rule, would reduce provider payments well below the cost of providing such care. Specifically, I have been told that these proposed reductions do not take into account the costs of doing services in real time and therefore would result in providers being reimbursed below cost. To that end, I would like answers to the following questions**

    a. **How up to date is the cost data CMS used to justify reductions to dialysis reimbursement under Medicare? Please explain.**

Answer: The ESRD Prospective Payment System (PPS) uses the most currently-available claims data to annually update the payment rate. As required by section 1881(b)(14)(A)(ii) of the Social Security Act ("the Act"), the ESRD PPS base rate was developed using Calendar Year (CY) 2007 claims data which was the lowest per patient utilization year, updated to CY 2011. The ESRD PPS base rate is then adjusted for patient-specific case-mix adjustments, applicable facility adjustments, geographic wage differences in area wage levels using an area wage index, as well as applicable outlier payments, or training payments, in accordance with section 1881(b)(14)(D) of the Act. Finally, in accordance with sections 1881(b)(14)(F)(i)(I) and (II) of the Act, the ESRD PPS payment amounts are annually increased by the rate of increase in the ESRD market basket, reduced by the productivity adjustment.

With respect to reductions to dialysis reimbursement, the American Taxpayer Relief Act of 2012 (ATRA) provision specifies, for services furnished on or after January 1, 2014, the Secretary shall make reductions to the single payment for renal dialysis services to reflect the Secretary's estimate of the change in the utilization of ESRD-related drugs and biologicals (excluding oral-only ESRD-related drugs) by comparing per patient utilization data from 2007 with such data from 2012. Therefore, in the ESRD PPS CY 2014 proposed rule, CMS calculated the amount of the per treatment adjustment by applying CY 2014 prices for ESRD-related drugs and biologicals to the utilization data for CY 2007 and CY 2012. Lastly, we proposed to price the ESRD- related drugs and biologicals for 2014 because we believe that they should be priced for the year in which the adjustment applies. We are taking comments on our proposed methodology to implement the reduction for drug utilization required by ATRA.

b. Does CMS expect that the cost data used will be updated in the next year? Please, in the context of a detailed response, provide a yes or no answer.

Answer: No. The ATRA provision requires that the adjustment be implemented beginning January 1, 2014. The provision also requires that the adjustment reflects the change in utilization by comparing 2007 and 2012 utilization data, which is the data the Agency is using in the proposal. CMS is carefully reviewing public comments to the proposed rule related to this adjustment.

c. Congress passed the American Taxpayer Relief Act (ATRA) on January 1, 2013, which in part required the agency to modify ESRD payments. Providers of services have suggested that this modification will result in negative margins. Does CMS have data that either supports or refutes this contention? If it does not, do you believe the concerns of negative margins are valid?

Answer: An impact analysis is completed for every proposed and finalized payment rule. Included in the CY 2014 ESRD PPS proposed rule is an impact analysis estimating that the overall impact of the CY 2014 changes are projected to be a 9.4 percent decrease in payments (compared to estimated payments in CY 2013). Hospital-based ESRD facilities have an estimated 9.3 percent decrease in payments compared with freestanding facilities with an estimated 9.4 percent decrease.

Although we proposed to implement the full reduction in CY 2014, we noted our concern that a one-time reduction to the ESRD PPS base rate could be a significant payment reduction to ESRD facilities for the year and potentially impact beneficiary access to care. Therefore, we solicited comments on a potential transition or phase-in period of the reduction and the number of years for such transition or phase-in period.

d. When preparing its proposed rule, did CMS identify any subgroups of patients that might be negatively impacted by the proposed rule? If not, did CMS study the impact that the proposal might have on patient subgroups? Please explain.

Answer: Although, the CY 2014 ESRD PPS proposed rule only includes an impact analysis for providers, we do have a separate monitoring program in place where beneficiary outcomes are monitored.[1] As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system when we implement the reduction required in section 632(a) of ATRA.

2. In the proposed rule for the 2014 Hospital Outpatient Prospective Payment System (HOPPS), CMS packages together certain skin substitutes, including certain skin substitutes that were approved by FDA with others that were not. How did CMS take the FDA approval process into account when drafting its proposed rule?

[1]This data is made public on the CMS Website at www.cms.gov/Medicare/Medicare-Fee-for-Servicepayment/ESRDpayment/Spotlight.html.

Answer: CMS is proposing to package categories of items and services that are integral, ancillary, supportive, dependent, or adjunctive to a primary service. Skin substitutes are integral to the treatment of a wound. Therefore, we are proposing to package skin substitutes with the primary wound treatment procedure under the Outpatient PPS (OPPS). While all products classified by CMS as skin substitutes are regulated by the Food and Drug Administration (FDA) as either medical devices or as human cell, tissue, cellular and tissue-based products, the precise type of FDA approval or clearance route was not a factor in our packaging proposal. All of the skin substitutes that are currently separately paid are proposed to be packaged for the 2014 OPPS. CMS is carefully reviewing public comments related to this proposal.

3. **For states that have deferred to a federally facilitated exchange, when does the Medicaid Maintenance of Effort (MOE) expire?**
4. **Will you be issuing further guidance on the Medicaid (MOE) and its expiration for states that have deferred to a federally facilitated exchange? If so, when?**

Answer to #s 3 and 4: The Medicaid maintenance of effort (MOE) requirement, first implemented as part of the Recovery Act and extended by the Affordable Care Act, generally ensures that states' coverage for adults under the Medicaid program remains in place pending implementation of coverage changes that become effective in January 2014. The MOE for children under age 19, in both Medicaid and the Children's Health Insurance Program (CHIP) is effective through September 30, 2019.

CMS has issued several State Medicaid Director letters related to the implementation of the MOE provisions[1]. That guidance describes the applicability of the MOE as well as the period of time in which the MOE is in place. CMS staff works closely with states to answer questions related to guidance issued by the Agency and remains engaged with states on issues of Affordable Care Act implementation. CMS does not anticipate releasing further guidance. On January 1, 2014, when an Exchange will be fully operational in every state, the MOE for adults will end.

5. **Please provide the national average error rate associated with Medicaid eligibility errors for Fiscal Years (FY) 2012, 2011 and 2010? Please describe such errors as they related to Medicaid eligibility determinations.**

Answer: CMS annually estimates the amount of Medicaid improper payments and submits those estimates to the Congress. The Payment Error Rate Measurement (PERM) program uses a 17-state three-year rotation for measuring improper payments in Medicaid, so that CMS measures each state once every three years. This process generates national rolling error rates based on data from the most recent three state cycles. The national PERM rates associated with Medicaid eligibility for Fiscal Year (FY) 2012 was 4.9 percent; for FY 2011 was 6.1 percent, and for FY 2010 was 5.9 percent.[2]

[2] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/PERM-MedicaidErrorRates.pdf ; http://wayback.archive-it.org/3922/20131030171300/http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf

6. **Please provide the amount of overpayments associated with Medicaid eligibility errors for FY2012, FY2011 and FY2010?**

Answer: Overpayments associated with Medicaid eligibility errors totaled $424,500 from FYs 2010-2012.

7. **CMS and CMMI have acquired by this point a good deal of experience administering the ACO and Medicare Shared Savings Programs. For example, CMMI recently announced results from the first year of the Pioneer ACO program. What remains unclear are the specific monitoring activities you have undertaken to assess ACO performance and to ensure beneficiary access to high quality care.**

    a. **Would you please describe the details of the monitoring program you have in place to ensure that beneficiaries assigned to ACOs under the Shared Savings Program or other CMMI initiative have access to the care they need? Have you done claims analysis, medical record audits of persons assigned to ACOs and what have been the results?**

Answer: In the short time that the programs have been running, we have implemented several monitoring activities to ensure beneficiaries have access to the care they need. CMS requires an annual survey of beneficiaries assigned to all Medicare accountable care organizations (ACOs) in either the Shared Savings Program or the Pioneer ACO Model. These surveys are intended to hold ACOs accountable for patient experiences of care, and scores on patient surveys affect the amount of shared savings or shared losses that the ACO may incur. In addition to the annual survey of beneficiaries, ACOs are required to report their performance on quality measures. As of July 2013, all Pioneer ACOs successfully reported quality measures and achieved the maximum reporting rate for the first performance year, with all earning Physician Quality Reporting System (PQRS) incentive payments for their reporting accomplishments. Overall, Pioneer ACOs performed better than the national average for all 15 clinical quality measures for which published comparable data are available. Quality measurement results for the first performance year of Shared Savings Program ACOs are expected in summer 2014.

CMS also oversees ACO participants themselves in several ways. CMS screens all ACO participants to ensure they are Medicare enrolled providers and have not been excluded from participation in Medicare programs. We review marketing materials used by ACOs to ensure they make clear that beneficiaries may see any Medicare provider they choose. We ensure ACOs are publicly reporting information such as the ACO's name, contact information, and leadership.

In addition, CMS funds an ACO compliance oversight, monitoring, and audit design and operational support contractor. The services provided by this contractor are primarily centered on developing protocols and performing compliance audits to ensure ACOs and their participating providers are in compliance with the terms and conditions of their formal agreement with CMS. Finally, to safeguard against reductions of necessary care, CMS analyses data on service utilization and may investigate utilization patterns through comparison surveys of beneficiaries aligned with the ACO and those in the general beneficiary population.

b. **Your report on the first year of the Pioneer ACO program compares ACO quality performance on several dimensions of care to findings of published literature—some of which, as cited by the report, is over a decade old. Are you also comparing patients inside and outside ACOs, in real time, to detect differences in their use of specific services, referrals to specialists, etc. and, if so, what have you found?**
c. **What have surveys of providers revealed about ACOs and the care they provide? Do you have a schedule for surveying beneficiaries assigned to ACOs on a regular basis?**

Answer to #s 7b and c: For the first year, Pioneer ACOs were paid for reporting the measures, given that the model was in its first year. CMS will be moving to pay-for-performance quality reporting in Pioneer ACO quality performance year 2, based on benchmarks that CMS established using available empirical data. All Pioneer ACO providers earned their PQRS incentive payments as a result of Pioneers reporting on quality measures which continue CMS' efforts to align our quality reporting and performance initiatives and reduce provider burden.

CMS requires an annual survey of beneficiaries assigned to all Medicare ACOs (in either the Shared Savings Program or the Pioneer ACO Model). These surveys are intended to hold ACOs accountable for beneficiary experiences of care. The ACO's scores on beneficiary surveys affect the amount of shared savings or shared losses that the ACO may incur.

Pioneer ACOs performed very well on the patient experience survey. Of the seven survey questions used to assess ACOs, four have published national Medicare fee-for-service results from 2011. Pioneer ACOs were rated higher by ACO beneficiaries on all four measures when compared to the 2011 Medicare fee-for-service results. For example, ACO beneficiaries rated Pioneer ACOs higher on receiving timely care and appointments (81 percent vs. 74 percent) and experiencing good provider communication (93 percent vs. 90 percent) than the national Medicare fee-for-service results.

d. **What are your plans for monitoring the care that will be provided to beneficiaries by the approximately 450 providers you anticipate will participate in CMMI's bundling initiative?**

Answer: Organizations participating in the Bundled Payments for Care Improvement initiative must meet rigorous standards for care quality and beneficiary satisfaction. To assess the quality of care furnished by the organizations and safeguard against stinting of care, CMS has created a monitoring program that includes asking beneficiaries about their experiences and measuring the quality provided by participating organizations. Organizations participating in the Bundled Payments for Care Improvement initiative must achieve certain quality thresholds in order to continue participating in the initiatives.

CMS will also monitor patient access to care to determine if providers are engaging in inappropriate activities, such as stinting on care. We will focus on monitoring utilization and cost increases to look for patterns of utilization that are indicative of poor quality (e.g., increased

readmissions). We will monitor for changes in patient case-mix and episode costs at participating and non-participating providers. A key source of information in this area will be claims records, which will allow us to examine patterns of care among participants relative to comparison groups, and the B-CARE Tool, a streamlined version of the Continuity Assessment and Record Evaluation (CARE) Item Set. The B-CARE Tool measures the health and functional status of Medicare beneficiaries at discharge from the acute setting.

e. I haven't been able to find very specific information about the quality measures that will be used in the Bundling Initiative. Could you please describe the quality measures that will be used in each of the four models of the Bundling Initiative?

Answer: The Bundled Payments for Care Improvement initiative will include measures that examine structural and organizational characteristics, patient case-mix, clinical care and patient safety, patient experience of care, and utilization and cost. The proposed measures and evaluation strategies for the Bundled Payments for Care Improvement models and clinical episodes were assessed based on their scientific rigor, validity, reliability and associated provider data collection burden. The data sources for these measures include CMS administrative data such as claims and post-acute assessment data, CMS quality reporting program data, survey data, provider submitted data, primary data gathered through modalities such as focus groups, and registry data as feasible.

8. CMMI recently announced the results from the first year of the CMMI Pioneer ACO program. According to your report, 13 of 32 Pioneer ACOs produced shared savings with CMS. However, several of these "Pioneers" will be transitioning into the Medicare Shared Savings Program, and two will leave the ACO program entirely.

a. How have the 13 Pioneers with shared savings used their savings? What portion of an ACO's savings was shared with providers participating in the ACO? What is the range in amounts received by individual providers?

Answer: Pioneer ACOs had to submit a preliminary plan for shared savings distribution in their applications and are required to keep a record of how they distribute shared savings. All Medicare ACOs are also required to publicly report at an aggregate level how they distribute earned shared savings. However, CMS does not prescribe the distribution methodologies or require detailed reporting (for example, at the level of individual providers). In some cases, information on provider compensation may be proprietary, particularly in markets where multiple Medicare ACOs operate.

b. Can you identify the participants that will not be returning to the program and their reasons for doing so?

Answer: Nine Pioneer ACOs submitted notices of intent to withdraw in the second year of the Pioneer ACO model: Prime Care Medical Network Inc., University of Michigan, Physician Health Partners LLC, Seton Health Alliance, Plus (North Texas Specialty Physicians and Texas Health Resources), Healthcare Partners Nevada ACO LLC, Healthcare Partners California

ACO LLC, JSA Care Partners LLC, and Presbyterian Healthcare Services. Seven out of these nine are applying to transition to the Medicare Shared Savings Program.

The Pioneer ACO Model is testing whether ACOs can succeed in payment arrangements that include higher levels of risk and reward than in the Medicare Shared Savings Program. Each of these organizations made its decision to apply for the Shared Savings Program or leave the Pioneer ACO model based on its particular business priorities and concerns. CMS fully expected that some ACOs would change the model in which they participate in over time, and our model savings projections took these changes into account. The Pioneer Model continues to test innovative models and generate important data and lessons learned for CMS.

c. Can you elaborate on the results of the first year of the Pioneer ACO program and the impact on patient access to new technology?

Answer: Medicare ACOs must meet rigorous standards for care quality and beneficiary satisfaction. To assess the quality of care furnished by the organizations and safeguard against stinting of care, CMS has created a vigorous monitoring program that includes asking beneficiaries about their experiences as well as measurement of the quality provided by participating organizations. ACOs must achieve certain quality thresholds in order to continue participating in the initiatives.

Beneficiaries retain their original Medicare benefits and may choose to receive care from providers not participating in the initiative. Nothing in the initiatives will in any way restrict the ability of beneficiaries to access care from participating or non-participating providers, nor will it restrict the ability of participating ACOs to offer the latest medical technologies. ACOs have significant flexibility to invest in redesigned care processes for high quality and efficient service delivery, including implementing innovative technologies.

9. The ACO program requires providers to meet only 33 quality measures to qualify for shared savings. These quality measures are mostly process measures as to whether specific actions were taken in the face of a certain set of clinical circumstances.

a. While important, the 33 ACO quality measures are hardly sufficient to fully assess care. In fact, there are huge gaps. There are no quality standards for cancer treatment (only cancer screening). There are no quality standards for stroke. There are no quality standards for Alzheimer's disease, for Parkinson's disease, or for any neurological condition. There are no standards for arthritis. The list goes on and on. Do you believe that these few measures are sufficient to measure the quality of care provided to the millions of beneficiaries enrolled in this new ACO program? Do you anticipate changes to the quality measures in the near future to address some of these gaps?

Answer: In the Medicare Shared Savings Program, ACOs are accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to the ACO. ACOs have significant flexibility to invest in redesigned care processes for high quality and efficient service delivery, including implementing innovative technologies.

The quality metrics proposed for ACOs and finalized after consideration of public comments were a careful balance between ensuring that quality of care is maintained while decreasing the reporting burden on ACOs. CMS is committed to developing and adopting a mix of process, outcome, and patient experience of care measures, including measures of safety, care transitions, and changes in patient functional status. As the science of quality measurement evolves, we will be able to make determinations on which measures are the most meaningful to providers and health care professionals and will most effectively drive progress and improvement. In future rulemaking for the Medicare Shared Savings Program, we anticipate reviewing the selected quality measures and seeking public comment on other measures that could be used by ACOs.

b. Is it possible that a physician's quality measure score could be penalized for using more clinically appropriate technology that is in the best interests of the patient? Will you provide a mechanism to adjust the quality scores for provides who deliver advanced care not yet reflected in the quality measures?

Answer: CMS established the 33 quality measures through notice and comment rulemaking and reviewed extensive comments on the proposed measures from provider groups, industry associations, patient organizations, medical associations, and other parties before finalizing the list of quality measures through the rule making process.

These quality measures employed in the Pioneer ACO Model and the Shared Savings Program are developed by measure stewards and many are endorsed through a National Quality Forum (NQF) endorsement process, a thorough vetting process which relies on input from numerous stakeholders including the provider community to ensure that measures are in line with best practice and appropriate for the purpose of assessing quality. Because CMS prioritizes using measures that are NQF-endorsed, the agency relies on measure developers and measure stewards to incorporate new standards of care and/or exceptions for new technologies/treatments into measure specifications.

The selected measures align with those included in other CMS quality reporting programs (such as the Physician Quality Reporting System, the EHR Incentive Program, and the Value-Based Payment Modifier/Quality Resource Use Reports) in an effort to reduce provider reporting burden and harmonize requirements across programs.

We believe that an ACO's quality measurement score would be enhanced when ACO providers use clinically appropriate technology and we think ACOs have an incentive to use the latest medical technology to improve their quality scores. We note that several of the quality measures incorporate risk adjustment, to account for differences in patient populations (such as by age, sex, and condition), so that an ACO's performance on those quality measures accounts for ACOs that happen to see a more sick or elderly population of patients.

The Honorable Greg Walden

10. In 2010, the local Chamber of Commerce in Bend, Oregon, received approval to sponsor its own Multiple Employer Welfare Agreement, or MEWA, health plan for member companies. With the approval of this plan, the Chamber was able to offer a locally tailored health plan to 2000 employees working for 141 businesses in Central Oregon. In coordination with this, I also sent a letter to the Department of Labor and the Department of Health and Human Services, dated March 31, 2010 asking that both agencies protect this plan, and plans like it, so that those employees truly could, as the President said, can keep their plan if they like it. I greatly appreciate Secretary Sebelius' response to my letter, in which she stated that she was "pleased that the MEWA designation has worked for small business owners in your district." In 2013, however, I received a letter from the facilitator of this plan that under new federal guidelines it is not likely to qualify.

Will HHS commit to doing all they can, by for instance working with the Department of Labor, to ensure that this plan is able to keep offering coverage to these employees, so that they truly can keep the coverage they like?

Answer: Your question raises the issue of how health insurance coverage provided to an association of employers is treated under the Public Health Service Act, as amended by the Affordable Care Act. We continue to examine these issues and are working with the Department of Labor.

11. Patient activation and engagement, in my view, are extremely important to ensuring high quality care for patients and families. Giving patients, providers, and families, the tools to best manage their own health care decisions simply makes the most sense. In fact, research has shown that patients who are more engaged in their health care demonstrate better outcomes. The health law made a lot of references to patient activation and engagement, and I hope that the Administration will hold true to that promise. For example, Section 3022\1899 (2) (G-H) requires the establishment of quality and performance measures for Accountable Care Organizations (ACOs) pertaining to patient engagement, patient-centeredness and the use of patient and caregiver assessments. We're all aware of the recent struggles with the new ACO program, both in the first phase and now even with the new, supposedly more improved program. Additionally, measurement of activation using the Patient Activation Measure is required for organizations funded through section 3026, the Community Care Transition Program CCTP). I am interested in hearing about how CMS is using patient engagement to improve care, reduce costly admissions through the CCTP; and how patient engagement is utilized to increase patient success through ACOs.

Has CMS collected data on the impact that patient activation measurement has on improving outcomes and lowering costs for ACOs and CCTP participants? As the CMS continues to test the impact of arrangements to help organizations achieve the goals of providing better care to patients and reducing costs will it require the measurement of patient activation and subsequent patient engagement efforts? What are other

opportunities for CMS to utilize patient activation and engagement to secure improved outcomes?

Answer: CMS shares your belief in the importance of patient engagement and activation. We put the patient at the center of all of our ACO programs and the Community-Based Care Transitions Program. CMS requires an annual survey of beneficiaries assigned to all Medicare ACOs in either the Shared Savings Program or the Pioneer ACO Model. These surveys are intended to hold ACOs accountable for patient experiences of care, and scores on patient surveys affect the amount of shared savings or shared losses that the ACO may incur. Pioneer ACOs have completed their first performance year and they performed very well on the patient experience survey. Of the seven survey questions used to assess ACOs, four have published national Medicare fee-for-service results from 2011. Pioneer ACOs were rated higher by ACO beneficiaries on all four measures when compared to the 2011 Medicare fee-for-service results. For example, ACO beneficiaries rated Pioneer ACOs higher on receiving timely care and appointments (81 percent vs. 74 percent) and experiencing good provider communication (93 percent vs. 90 percent) than the national Medicare fee-for-service results. Quality measurement results for the first performance year of Shared Savings Program ACOs are expected in summer 2014.

While participating in the Shared Savings Program or the testing of the Pioneer ACO model, ACOs take part in learning and diffusion activities in which topics such as patient engagement are discussed. This allows ACOs to share their experiences and learn from other ACOs how to improve on their patient engagement processes.

Under the Community-based Care Transition Program (CCTP), data collected by a patient experience survey is used as part of the intervention. Patient activation and engagement are key to determining how to tailor an intervention plan so that it meets not only the medical needs of the patient but also their psychosocial needs.

The Patient Experience Survey draws questions from three existing and validated instruments. The survey items assess: beneficiaries' perception of their hospital experience specifically related to medicines and discharge plans for a recent hospital stay; how well the hospital prepared patients to care for themselves after discharge; and beneficiaries' perceptions of self-efficacy (knowledge, confidence, and skills) for managing their own health behaviors and health care following a hospital stay.

By comparing survey responses from questions presented at both the first and second administration of the survey, sites are able to determine if the intervention has made a difference in the patient's level of activation. In turn, this data aggregated across sites is critical in determining whether the interventions are having their intended impact. The community based organizations that work with eligible hospitals to help reduce readmissions will use the information to tailor the care transition services to the specific needs of the beneficiary and target areas where gaps in knowledge have been identified.

The patient experience survey has been available for voluntary use by CCTP participants since the program's inception. Required use of the survey will start in August 2013 and all CCTP sites

will be required to submit the patient experience survey by September 2013. A contractor will collect, analyze and report the survey data to CMS and the individual CCTP programs on a quarterly basis.

The Honorable Michael C. Burgess

12. The Medicare Payment Advisory Commission projected ESRD margins to be around 3-4 percent. The 9.4 percent cut proposed by the Agency eliminates that margin and would result in negative margins, if not for every facility, at least the majority of them. Do you think it is possible for entities where 85 percent of the patients are Medicare beneficiaries to continue to provide quality care if they are getting reimbursed by Medicare below the cost of providing care?

Answer: The proposed reduction is required under section 1881(b)(14)(I) of the Act, as added by section 632(a) of ATRA. Section 1881(b)(14)(I) requires that the Secretary make reductions to the Medicare single payment amount for ESRD facilities under the PPS to reflect the Secretary's estimate of the change in utilization of drugs and biologicals (other than oral-only ESRD-related drugs) from 2007 to 2012. While we proposed to implement the full reduction to the ESRD PPS in CY 2014, we are soliciting comments on use of a potential transition or phase-in period for the reduction and the number of years for such transition or phase-in period. As CMS did in implementing the ESRD PPS in 2011, we will continue to closely monitor health outcomes and access using our active claims surveillance system when we implement this required reduction.

13. Many low-cost glucose meters are the primary source of device inaccuracies in the market while many commercially marketed meters, do not meet current International Standards Organization (ISO) standards. Given the inaccuracies of blood glucose meters, are you concerned that CMS' Medicare Competitive Bidding Program is creating a dynamic where decisions are made on price alone and such decisions will put patients at risk?

Answer: All Medicare DMEPOS suppliers must furnish items that meet applicable FDA regulations and medical device effectiveness and safety standards. In order to furnish any DMEPOS for Medicare beneficiaries, all suppliers must be in compliance with the Medicare supplier standards and quality standards. The Medicare quality standards require suppliers to implement a program that promotes the safe use of equipment.

In response to concerns about beneficiary access to their preferred brand of test strips under the DMEPOS competitive bidding program, Congress mandated in section 1847(b)(10) of the Act that suppliers competing under the national mail order program for diabetic testing supplies demonstrate that their bid covers the cost of at least 50 percent of the brands of test strips on the market by volume. The HHS Office of Inspector General gathers the market volume data needed to implement this rule, and CMS uses invoices and purchase orders from suppliers to verify that their bids cover these costs. In addition to this "50 percent rule," Medicare rules include an "anti-switching" provision as a term of the contract for suppliers under the national mail-order competition for diabetic supplies. This regulation prohibits contract suppliers from influencing or incentivizing beneficiaries to switch their current glucose monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor selected by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors. The DMEPOS competitive bidding

program also includes an anti-discrimination policy, meaning that suppliers have to offer their Medicare beneficiaries the same products they offer their other customers. Further, contract suppliers are required to furnish a particular brand prescribed by a physician or assist the beneficiary in finding another contract supplier who will furnish the item, or consult with the physician to find a suitable alternative and obtain a revised prescription. This requirement applies to all product categories.

14. The HHS Office of Inspector General issued a report in November 2012 entitled *Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas.* The study shows a dramatic reduction –18 percent- in claims for testing supplies associated with Competitive Bidding. If only 1 percent of the reduction in claims is due to diabetes patients stopped testing, the drop in claims is clinically significant and could be potentially devastating for the diabetes community and for our health care system. What is CMS doing to determine the reason for the dramatic reduction in claims?

Answer: CMS has implemented a robust monitoring program to track and resolve any issues that might occur with program implementation. To date, the program has maintained beneficiary access to quality products from accredited suppliers in the Round 1 Rebid areas. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency department visits compared to non-competitive bidding areas. We have investigated the reduction in claims for diabetic testing supplies in the Round 1 competitive bidding areas and found that this reduction is due to beneficiaries having an oversupply of these products. Specifically, we contacted a sample of beneficiaries who were using diabetic testing supplies before the Round 1 Rebid phase of the program began in nine areas in 2011, and for whom no claims for diabetic testing supplies were received during the first six months of the program (*i.e.*, through June 2011).

We found that most of these beneficiaries were still using diabetic testing supplies to manage their diabetes, and in some cases, beneficiaries had more than enough diabetic testing strips to last them over six months without having to reorder. We will continue to monitor access to quality products and promptly address any issues.

15. The need to have a face-to-face encounter or direct interaction with a physician is important and needed. The question is why did CMS choose the current method for implementing the face-to-face requirement? As you are aware, prior to billing for Medicare home health services, home health agencies must obtain a signed and dated form from the physician which outlines the full plan of care. This comprehensive form, known as the 485 form, includes the complete plan of care which will be delivered by the home health agency.

a. Since this form is completed and signed by the physician, would CMS consider accepting a modified version of this form and or an attestation of a face-to-face from the physician to comply with this regulation? Or at a minimum why does

CMS not offer a sample format or one consistent form for all physicians to use that satisfies the face-to-face documentation requirement?

Answer: In an effort to implement the face-to-face requirements with as much flexibility as possible for both home health agencies and physicians, CMS allows the certifying physician or his or her support staff to generate or extract documentation for the certifying physician's signature from the physician's electronic medical record entries. In the case of patient admitted to home health from an acute or post-acute care facility, discharge planners who have access to medical record entries of the physician who attended to the patient during the institutional stay may extract the encounter documentation for the certifying physician's signature.

CMS does not require certifying physicians to document, sign, and date an additional form in order to satisfy the home health face-to-face requirements. CMS does not require a specific form for face-to-face documentation or for the certification which includes the face-to-face documentation. Our regulations require that the documentation of the face-to-face encounter be a separate and distinct section of, or addendum to, the certification, and that the documentation include why the clinical finding of the encounter supports home health eligibility. The face-to-face documentation must be clearly titled and dated, and signed by the certifying physician.

Access to care is of paramount importance to CMS. We will continue to monitor the effects of the face-to-face requirements for unintended consequences and to work proactively with HHAs and other stakeholders to ensure eligible Medicare beneficiaries maintain access to home health care.

The Honorable Marsha Blackburn

16. **On July 3, the Centers for Medicare and Medicaid Services (CMS) issued a proposed national coverage decision memorandum outlining its Coverage with Evidence Development (CED) for positron emission technology (PET) beta-amyloid imaging for dementia and neurogenerative disease. This decision denies Medicare coverage for an FDA approved technology for Medicare patients. How does limiting access to diagnostic technology fulfill the Obama Administration's National Alzheimer's Plan, which makes early diagnosis a priority?**
17. **Alzheimer's disease is estimated to cost the nation $200 billion this year alone, and about 70 percent of that - $140 billion – is shouldered by taxpayers in Medicare and Medicaid costs. This is projected to exceed 1.2 trillion by 2050 in the absence of interventions. Leading experts as well as our government through the National Alzheimer's Plan (NAPA) have stressed the value of an early and accurate diagnosis in treating Alzheimer's to prevent costly and time-consuming misdiagnoses, as well as begin proper care planning earlier.**

    I am wondering how a recent draft decision by CMS to deny Medicare coverage of an FDA diagnostic tool for Alzheimer's disease is in the best interest of patients or taxpayers who would benefit from accurate diagnosis and more appropriate medical treatment plans based on an early & accurate diagnosis.

Answer to #s 16 and 17: The proposed decision represents an expansion of coverage rather than a denial. As such, it exemplifies our ongoing efforts to review new technology to ensure timely access to innovative products that may benefit our beneficiaries, including those with Alzheimer's disease. In October 2012, CMS opened a National Coverage Analysis (the first step in the National Coverage Determination (NCD) process) to reconsider a prior NCD on the use of Positron Emission Tomography (PET) scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by Eli Lilly & Company to consider coverage of PET using a new type of radiopharmaceutical approved by FDA in 2012 to image beta-amyloid plaques in certain patients being evaluated for Alzheimer's disease and other causes of cognitive decline.

To help inform this evidence review, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) in January 2013. On July 3, 2013, CMS issued a proposed coverage decision, followed by a 30-day public comment period. As you noted, the proposed NCD would allow Medicare coverage of beta amyloid PET scans for diagnosis of dementia and neurodegenerative disease under the process known as "coverage with evidence development" (CED) for patients enrolled in an approved clinical study. CED is used as an alternative to non-coverage for certain items and services for which CMS has determined that the best available evidence does not support unrestricted coverage. This process allows access to emerging technologies while promoting the development of further clinical evidence. CMS' evidence-based coverage decision-making process (including use of CED) is not meant to replace or duplicate FDA's determination of a product's safety and effectiveness; rather, it is designed to meet CMS' statutory obligation to

ensure that Medicare covers only items and services determined to be "reasonable and necessary" for our beneficiaries.

CMS received 202 comments on the proposed decision, which are currently under review. CMS will carefully consider those comments in developing a final coverage decision.

18. **In May, the Tennessee Department of Health Licensure identified 29 contracted durable medical equipment companies who were initially awarded contracts were not licensed by the state of Tennessee thus becoming ineligible for Round II of competitive bidding. However, some of these companies are still listed as contract suppliers on the Medicare website and are still active suppliers in their contracted CBAs either directly or through a sub-contractor who is licensed. Both of these scenarios are in clear violation of the program rules. In a letter dated June 14, 2013, you notified TN Members of Congress that "CMS will take steps to void contracts for these suppliers in the Tennessee competitive bidding areas, consistent with the policies and guidelines established for the competitive bidding program. This applies to approximately 30 out of the 98 contract suppliers in the Tennessee Competitive Bidding Areas". When will CMS release the names of these 30 companies who were supposedly revoked? When will CMS revoke all contracts of these ineligible suppliers as indicated?**

Answer: We carefully examined Tennessee licensing requirements and spoke to state officials in order to obtain clarity on these requirements. We determined that certain out-of-state suppliers were licensed in their home state, but did not meet aspects of existing Tennessee licensing requirements at the time of bid submission for DMEPOS competitive bidding. As a result, in June 2013, CMS voided contracts for 30 out of 98 contract suppliers in the Tennessee competitive bidding areas, consistent with the policies and guidelines established for the competitive bidding program. CMS is required by law to protect the confidentiality of suppliers' confidential bid information, which includes information related to voided contracts. Therefore, we cannot release the names of contract suppliers whose Tennessee contracts have been voided. We are closely monitoring beneficiary access to competitive bidding items in Tennessee. We may consider making new awards to qualified and licensed suppliers in the future if needed.

19. **On June 14, 2013, you announced that 30 of the 98 companies contracted for Tennessee's Competitively Bid Areas were in violation of the Competitive Bidding Program licensure requirement and would be revoked. Per the Final Rules, published April 10, 2007, "The single payment amount will be determined only from those bids that are considered 'acceptable,' meaning that the supplier meets all quality, financial, and eligibility standards and that the bid is in the winning range". It goes on to state, "As a result, only bids from eligible, qualified, and financially sound suppliers will be used to determine the single payment amounts and select contract suppliers". Based on the specific and clear guidelines for calculating the Single Payment Amount, why has CMS not recalculated the Single Payment Amounts excluding the unlicensed contracted companies' bids for the affected CBAs?**

Answer: CMS does not make changes to the single payment amounts calculated for each item under each DMEPOS competitive bidding program. These amounts are paid for the duration of

the competitive bidding program and will not be adjusted for any update factor. During the contract process, suppliers agree to accept the single payment amounts for a competitive bidding area. Any changes to the contracts, including the single payment amounts, would require CMS to reissue contracts to suppliers, which could potentially delay the program or terminate a competition in a competitive bidding area if suppliers decline contracts after prices are adjusted.

20. Earlier this week, CMS reported that the number of physicians opting out of the Medicare program entirely increased more than 250% between 2009 and 2012. As the Medicare-eligible population continues to expand, it is critical that our seniors have access to care, which can only be achieved with an adequate healthcare workforce willing to treat Medicare beneficiaries. One reason physicians have referenced as their motivation for leaving the Medicare program is the inability to offer their patients cutting edge technologies that are FDA-approved but do not have adequate coverage or payment under Medicare. How can the program evolve to accommodate these physicians' wishes to offer beneficiaries the best treatment available without pushing them out of Medicare?

Answer: According to HHS' latest findings on access to physicians' services by Medicare beneficiaries, the percentage of office-based physicians who report accepting new Medicare patients has not changed significantly between 2005 and 2012, with 87.9 percent accepting new Medicare patients in 2005 and 90.7 percent in 2012. The HHS analysis also notes that the percentage of physicians who report accepting new Medicare patients is similar to, and in recent years slightly higher than, the percentage accepting new privately insured patients.[3] Currently, approximately 9,500 physicians have opted out of Medicare while about 735,000 remain in Medicare.

In addition, CMS is continually engaged in reviewing new technologies through our national coverage determination process, notice-and-comment rulemaking, and other initiatives, with ample opportunities for public input. While CMS has separate statutory responsibilities from those of FDA, governed by different standards, we are exploring ways to better coordinate FDA and CMS processes. For example, in 2010, the two agencies jointly announced their consideration of, and requested public comments on, a voluntary "parallel review" process for overlapping evaluations of premarket, FDA-regulated medical products. In 2011, the agencies launched a "parallel review" pilot program for concurrent review of medical devices for FDA approval and Medicare coverage. CMS and FDA are currently working on two parallel review pilot projects. We believe the interactions between CMS, FDA and the sponsors have been encouraging for all participants.

21. The Affordable Care Act's expanded Medicaid benefit will put new beneficiaries at a serious disadvantage by restricting their prescription drug coverage below the level currently provided by Medicaid's standard benefit. In the final rule on Medicaid Alternative Benefit Plans, CMS extended the minimum coverage requirement for qualified health plans in the health insurance marketplaces to one drug per USP category and class or the same number of drugs per USP category and class as the state benchmark plan, whichever is greater. This standard could pose serious access

[3] Available at http://aspe.hhs.gov/health/reports/2013/PhysicianMedicare/ib_physicianmedicare.cfm.

problems for new Medicaid patients. The impact of limiting drug access will be particularly pronounced for rare disease patients who often require very specific therapies or a combination of treatments. The USP Model Guidelines do not account for many rare diseases. For instance, the USP lacks a class for cystic fibrosis therapies. A one drug minimum standard based on the USP guidelines could leave many individuals lacking the life-saving treatments they require. How is HHS planning to address this counterproductive limitation critical drug treatment? Will any considerations be made to protecting individuals with rare diseases to ensure they receive the therapies they require?

Answer: States have considerable discretion in the provision of Medicaid services including the ability to define the amount, duration, and scope of prescription drug coverage under an Alternative Benefit Plan. In developing these plans, states must include prescription drug coverage consistent with the Essential Health Benefit benchmark plan standards. These standards include the requirement that health plans have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. We believe such requirements will result in coverage that is similar to the coverage otherwise required under regular Medicaid state plan coverage.

22. On May 21, the Diabetes Technology Society hosted a conference with representatives from academia, FDA, and the diabetes industry to discuss the question, "Do currently available blood glucose meters meet regulatory standards?" There was broad consensus among participants that the answer is a resounding "no". And many low-cost meters are the primary source of device inaccuracies in the market. Many commercially marketed meters, do not meet current International Standards Organization (ISO) standards and the impact on patient health could be devastating.

a. Given the inaccuracies of blood glucose meters, are you concerned that CMS' Medicare Competitive Bidding Program is creating a dynamic where decisions are made on price alone and such decisions will put patients at risk?

Answer: All Medicare DMEPOS suppliers must furnish items that meet applicable FDA regulations and medical device effectiveness and safety standards. In order to furnish any DMEPOS for Medicare beneficiaries, all suppliers must be in compliance with the Medicare supplier standards and quality standards. The Medicare quality standards require suppliers to implement a program that promotes the safe use of equipment.

In response to concerns about beneficiary access to their preferred brand of test strips under the DMEPOS competitive bidding program, Congress mandated in section 1847(b)(10) of the Social Security Act that suppliers competing under the national mail order program for diabetic testing supplies demonstrate that their bid covers the cost of at least 50 percent of the brands of test strips on the market by volume. The HHS Office of Inspector General gathers the market volume data needed to implement this rule, and CMS uses invoices and purchase orders from suppliers to verify that their bids cover the costs. In addition to this "50 percent rule," Medicare rules include an "anti-switching" provision as a term of the contract for suppliers under the national mail-order competition for diabetic supplies. This regulation prohibits contract suppliers

from influencing or incentivizing beneficiaries to switch their current glucose monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor selected by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors. The DMEPOS competitive bidding program also includes an anti-discrimination policy, meaning that suppliers have to offer their Medicare beneficiaries the same products they offer their other customers. Further, contract suppliers are required to furnish a particular brand prescribed by a physician or assist the beneficiary in finding another contract supplier who will furnish the item, or consult with the physician to find a suitable alternative and obtain a revised prescription. This requirement applies to all product categories.

b. **At the above mentioned conference, participants highlighted many reasons why meters do not perform according to pre-market trials, underscoring the need for post-market quality enforcement. Post-market evaluations of commercially available meters highlights the problems with inaccurate systems and suggests that performance among "low cost", "non-branded" products show the greatest variability – in other words are producing inaccurate results for patients. Until FDA is able to better enforce compliance with existing FDA standards, isn't it irresponsible for CMS to implement Competitive Bidding that drives Diabetes Testing Suppliers to "low cost", "non-branded" products?**

Answer: CMS has implemented a number of requirements in the DMEPOS competitive bidding programs specifically for contract suppliers of diabetic testing supplies to ensure beneficiaries continue to have access to quality items. The law requires bidders for mail-order diabetic supplies to demonstrate that their bids cover at least 50 percent, by volume, of all types of diabetic testing strips on the market. In addition, bidders are required to submit the brands of the diabetic testing strips in their bids and this information is available on the Supplier Locator Tool for beneficiaries to determine which contract suppliers have the brands they want to use.

Medicare rules include an "anti-switching" provision as a term of the contract for suppliers under the national mail-order competition for diabetic supplies. This regulation prohibits contract suppliers from influencing or incentivizing beneficiaries to switch their current glucose monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor selected by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors. The DMEPOS competitive bidding program also includes an anti-discrimination policy, meaning that suppliers have to offer their Medicare beneficiaries the same products they offer their other customers. Further, contract suppliers are required to furnished a particular brand prescribed by a physician or assist the beneficiary in finding another contract supplier who will furnish the item, or consult with the physician to find a suitable alternative and obtain a revised prescription. This requirement applies to all product categories.

c. **The Medicare Competitive Bidding Programs drops reimbursement 72% for diabetes testing supplies. As a result, suppliers are forced to purchase the cheapest blood glucose monitoring systems available – including off shore products. FDA, at the May 21st Forum, acknowledged that it is hard for FDA to**

conduct inspections outside of the United States, particularly in Asia, and stated that it is concerned about unsafe blood glucose monitoring systems coming into the United States. Considering that some of the products now available to Medicare diabetes patients are from outside the US market and may not be from FDA inspected facilities, is it wise for CMS to implement a program that drives purchasers outside the US supply chain? What is CMS doing, in conjunction with FDA, to ensure that only FDA approved products reach diabetes patients? What is CMS doing, in conjunction with FDA, to ensure that blood glucose meters not only meet FDA standards at time of approval, but are undergoing post-clearance quality monitoring?

Answer: All Medicare DMEPOS suppliers must furnish items that meet applicable FDA regulations and medical device effectiveness and safety standards. In order to furnish any DMEPOS for Medicare beneficiaries, all suppliers must be in compliance with the Medicare supplier standards and quality standards. Currently, the name brand products made in the United States are being offered to Medicare beneficiaries by both the mail order and non-mail order outlets. The non-mail order suppliers are required to be paid the same Medicare payment rate as mail-order suppliers. Suppliers must accept the new payment amount as payment in full and may not charge the beneficiary any additional amount above the Medicare rates. As the products are available by mail order and non-mail order outlets, we believe that the DMEPOS competitive bidding program is not affecting access to name brand products and that beneficiaries are not improperly incurring any additional cost to secure name brand products. We will continue to monitor access to quality products and will act promptly to address any issues.

23. **The HHS Office of Inspector General issued a report in November 2012 entitled *Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas*. The study confirmed that, in the 9 Competitive Bid Areas (CBA), there was a significant shift to retail suppliers with the introduction of CMS' Competitive Bidding Program. The report suggested that the top reason for the shift was beneficiaries' loss of their supplier.**

    a. **Beneficiaries lost a great deal of product access and choice in the 9 CBAs under Round 1 of Competitive Bidding. We can expect this lack of access to be replicated in National Mail Order insofar as the winning suppliers adopt similar restricted choices. Given that this information was available prior to implementation of NMO, what, if anything, did CMS do to stem this behavior among suppliers to limit product availability?**

Answer: CMS has implemented a number of requirements in the DMEPOS competitive bidding programs specifically for contract suppliers of diabetic testing supplies to ensure beneficiaries continue to have access to quality items. The law requires bidders for mail-order diabetic supplies to demonstrate that their bids cover at least 50 percent, by volume, of all types of diabetic testing strips on the market. In addition, bidders are required to submit the brands of the diabetic testing strips in their bids and this information is available on the Supplier Locator Tool for beneficiaries to determine which contract suppliers have the brands they want to use.

Medicare rules include an "anti-switching" provision as a term of the contract for suppliers under the national mail-order competition for diabetic supplies. This regulation prohibits contract suppliers from influencing or incentivizing beneficiaries to switch their current glucose monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor selected by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors. The DMEPOS competitive bidding program also includes an anti-discrimination policy, meaning that suppliers have to offer their Medicare beneficiaries the same products they offer their other customers. Further, contract suppliers are required to furnished a particular brand prescribed by a physician or assist the beneficiary in finding another contract supplier who will furnish the item, or consult with the physician to find a suitable alternative and obtain a revised prescription. This requirement applies to all product categories.

b. The study shows a dramatic reduction - 18% - in claims for testing supplies associated with Competitive Bidding. Although CMS and OIG can point to anecdotal reports of overstocking, neither CMS nor OIG have provided data to confirm the 18% drop is due to overstocking. Furthermore, neither CMS nor OIG can show that the program is meeting the needs of beneficiaries for medically necessary testing. If only 1% of the reduction in claims is due to diabetes patients stopped testing, the drop in claims in clinically significant and could be potentially devastating for the diabetes community and for our health care system. What is CMS doing to determine the true reason for the dramatic reduction in claims?

Answer: CMS has implemented a robust monitoring program to track and resolve any issues that might occur with program implementation. We have investigated the reduction in claims for diabetic testing supplies in the Round 1 competitive bidding areas and found that this reduction is due to beneficiaries having an oversupply of these products. Specifically, we contacted a sample of beneficiaries who were using diabetic testing supplies before the Round 1 Rebid phase of the program began in nine areas in 2011, and for whom no claims for diabetic testing supplies were received during the first six months of the program *(i.e.,* thru June 2011). We found that almost all of these beneficiaries were still using diabetic testing supplies to manage their diabetes, and in some cases, beneficiaries had more than enough diabetic testing strips to last them over six months without having to reorder. We will continue to monitor access to supplies and equipment and promptly address any issues.

c. Is CMS prepared to stop the program or significantly overhaul the program if data shows that diabetes patients are no longer testing as a result of the implementation of the Competitive Bidding Program and lack of access to preferred diabetes testing supplies?

Answer: CMS has implemented a robust monitoring program to track and resolve any issues that might occur with program implementation. To date, the program has maintained beneficiary access to quality products from accredited suppliers in the Round 1 Rebid areas. Extensive real-time monitoring data have shown successful implementation with very few beneficiary

complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency department visits compared to non-competitive bidding areas. To the extent an issue arises, CMS will act promptly to address it.

24. On November 10, 2011, CMS published in the Federal Register a Final Rule that revised the definition of durable medical equipment ("DME") to add a three-year minimum lifetime requirement ("MLR") which products must satisfy in order to be eligible for reimbursement under the Medicare DME benefit category. The three-year MLR is only effective with respect to "new" items classified as DME after January 1, 2012. Items classified as DME on or before January 1, 2012 are considered to be "grandfathered items" and continue to fall within the DME benefit category regardless of whether they meet the 3-year MLR. Further, to the extent that a grandfathered item is "modified" after January 1, 2012 and is not a "new" product, it would continue to fall within the grandfathering provision and would not need to meet the 3-year MLR.

Answer: We believe you are requesting confirmation of what will be grandfathered. In a proposed rule published in the Federal Register on July 8, 2013, we clarified that the three-year minimum lifetime requirement would not be applied to grandfathered items that are modified (*e.g.*, refined or upgraded versions of the same product), provided the modified product did not have an expected life shorter than the expected lifetime for that item covered as DME prior to January 1, 2012. We invited public comments on this issue in this rule. The comment period for this rule ends August 30, 2013.

25. On July 8, 2013, CMS published in the Federal Register a Proposed Rule containing a clarification to the scope and applicability of the grandfathering provision. There may be modifications that can be made to a grandfathered product (including products with disposable components) that would result in more efficient and effective medical treatments (and thereby improve the health of Medicare beneficiaries) but reduce the minimum lifetime of the product. Under the Proposed Rule, a modified product would then be considered a "new" product that is not subject to the grandfathering provision and, therefore, not covered as DME.

a. What considerations were taken into account when determining whether this would restrict/preclude Medicare beneficiary access to such products?

Answer: We believe that the vast majority of the categories of items that were classified as DME before January 1, 2012 did function for three or more years. As beneficiaries have been relying on these items for treatment, applying the three-year minimum lifetime requirement could affect the continuity of care for these beneficiaries. We believe that continuing Medicare coverage for items that qualified as DME prior to the effective date helps avoid disrupting the continuity of care for beneficiaries that received these items for medical treatment prior to January 1, 2012.

26. The Proposed Rule does not provide clarity on what is a completely "new" product that would never be subject to the grandfathering provision, and a "modified" product that

would be subject to the grandfathering provision provided that the modifications did not result in a reduced minimum lifetime of the product.

a. How will CMS determine what constitutes a "modified (upgraded, refined, reengineered, etc.)" product under the Proposed Rule?

Answer: The three-year minimum lifetime requirement is designed to represent a minimum threshold for determination of durability of a piece of equipment and would apply prospectively only to new equipment furnished to a beneficiary after the regulation was effective on January 1, 2012. We proposed that if the product is modified after January 1, 2012, the item would still be classified as DME as a grandfathered item unless the modified product now has an expected life that is shorter than the expected lifetime for the item covered as DME prior to January 1, 2012. For example, if a product is modified such that it no longer lasts two years, we consider the modified product as a new item that is subject to the three-year minimum lifetime requirement. Our proposed rule has solicited comments on this issue.

b. Is a "modified" item required to fall within the same HCPCS code and/or DME product category as a grandfathered item in order for it to also fall within the grandfathering provision?

Answer: For purposes of providing additional guidance on the scope of grandfathered items, we invited public comments on this issue in this proposed rule. The comment period for this rule ends August 30, 2013. We will consider comments we received in order to provide additional guidance on this issue.

27. The Proposed Rule also proposes to reclassify certain items of DME from the "routinely purchased" payment category to the "capped rental" payment category. This would eliminate the purchase option for these items. Ultrasound BGS products are included in the proposal. CMS's proposal does not appear to account for the FDA regulatory framework that is inextricably tied to the development of DME products, including BGS products. BGS products are approved by the FDA for single patient use only, which is inconsistent with the purpose of a rental payment methodology. Rental permits suppliers to re-purpose an item of DME used for only a short time by one patient for another patient. This is not possible for BGS products as they are currently approved by the FDA. We are concerned that the proposal could create a significant regulatory burden for BGS manufacturers trying to reconcile FDA regulatory requirements with Medicare reimbursement.

a. How were these FDA regulatory requirements into consideration when deciding to move certain single-patient-use products to the "capped rental" payment category?

Answer: In the proposed rule, we are soliciting comments on reclassification of items that were previously classified as routinely purchased equipment to the capped rental payment class to comply with our current regulations. The proposal included the list of the HCPCS codes that would be reclassified so that stakeholders may comment. The comment period for this rule ends

August 30, 2013. We will consider this comment and other comments received on this issue when we make our final decision.

28. The Consumer-Oriented Plan Option in the ACA, otherwise known as CO-OPs, provide taxpayer backed startup and operational loans to health plans. One recipient in New York, the Freelancers Union, received a $340 million loan from the program. Rates filed by the Freelancers Union are not line in with other for-profit and non-profit insurers that have filed insurance rates with the state. Given this fact, has CMS reviewed these rates to ensure that the Freelancer Plan is meeting solvency requirements? Can CMS assure this Committee that the Freelancers Union, and other CO-OP recipients, will pay taxpayers back for the loans they have received under this program?

Answer: As you know, the state of New York, along with 16 other states plus the District of Columbia, has elected to operate a state-based marketplace. The state reviews all prospective qualified health plans (QHPs) applications including benefits and rates. The state also has prior approval authority over all rates charged. Once an issuer submits proposed rates, consumers have the opportunity to submit a public comment, the state reviews the materials, and the final approved rates are posted.

The CO-OP program provides start-up and solvency loans to help create new health insurance companies that will give more choices and control to consumers, promote competition, provide new models of care delivery and improve quality in the health insurance market. CMS shares the Committee's goal of assuring that CO-OP loans are fully repaid. We have in place extensive policies and procedures to monitor and support CO-OPs as they enter the market, gain membership, build adequate reserves, and, taking into account state reserve laws and regulations as required by the statute, ultimately repay CMS in a timely manner. The dual regulation of CO-OPs by both the state departments of insurance and CMS provides effective monitoring and mitigates risks.

The Honorable Leonard Lance

29. Given the Administration's focus on Alzheimer's disease via the National Alzheimer's Project Act and the recently announced BRAIN initiative, can you comment on why the agency recently issued a draft coverage decision to deny Medicare patients timely access to a FDA approved technology for diagnosing Alzheimer's disease?

30. As you know, the Administration's National Alzheimer's plan makes early diagnosis of Alzheimer's a priority for the country. In that context I am perplexed and disappointed that CMS recently issued a draft coverage decision that would deny Medicare coverage of FDA approved diagnostic tests to determine whether certain patients might have Alzheimer's disease. Can CMS revisit this draft decision denying coverage and instead adopt the appropriate use guidelines developed by the Alzheimer's Association and medical experts from the Society of Nuclear Medicine and Molecular Imaging that already deters any potential overutilization?

Answer to #s 29 and 30: The proposed decision represents an expansion of coverage rather than a denial. As such, it exemplifies our on-going efforts to review new technology to ensure timely access to innovative products that may benefit our beneficiaries, including those with Alzheimer's Disease. In October 2012, CMS opened a National Coverage Analysis (the first step in the NCD process) to reconsider a prior NCD on the use of PET scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by Eli Lilly & Company to consider coverage of PET using a new type of radiopharmaceutical approved by FDA in 2012 to image beta-amyloid plaques in certain patients being evaluated for Alzheimer's disease and other causes of cognitive decline.

To help inform this evidence review, CMS convened a meeting of the MEDCAC in January 2013. On July 3, 2013, CMS issued a proposed coverage decision, followed by a 30-day public comment period. The proposed NCD would allow Medicare coverage of beta amyloid PET scans for diagnosis of dementia and neurodegenerative disease under the process known as "coverage with evidence development" (CED) for patients enrolled in an approved clinical study. This process allows access to emerging technologies while promoting the development of further clinical evidence. CMS received 202 comments on the proposed decision, which are currently under review.

The Honorable David McKinley

31. The President's Executive Order #13563 requires that detailed and cumulative impact analyses be conducted for any proposed rule that is deemed to be economically significant like the Home Health Prospective Payment System (HHPPS) proposed rule. On page 111 of the HHPPS proposed rule, CMS correctly noted that "rebasing must be phased-in over a 4-year period in equal increments" -- meaning that the rebasing adjustment proposed in this rule will be implemented not only in 2014 but in 2015, 2016 and 2017 too. On that same page, however, CMS notes that it's "analysis describes the impact in 2014 only."

Why has CMS not complied with the Executive Order and publish its analysis of the impact of this rule in each of the 4 years in which it will take effect?

Answer: Based on the requirements of Executive Orders 12866 and 13563, respectively, the economic impact analysis for a prospective payment rule like the Home Health PPS proposed rule assesses many factors. including the rebasing adjustment, and presents the cumulative effects of the complete regulation (both costs and benefits) for the applicable year of implementation. As a part of the annual rulemaking process, the Home Health PPS impact analyses for subsequent years will be assessed in the applicable years of implementation, at which point all relevant data sources will be available, so that a cumulative effect of the complete regulation may be presented.

32. CMS has expressed uncertainty as to whether it has any flexibility in the rebasing adjustment that is to be imposed on the Medicare home health benefit. The statutory language in Section 3131 of the PPACA is clear in several important respects: (1) it does not require the Secretary to reduce home health payment rates as a result of rebasing; (2) it does not specify any specific adjustment that is to be imposed as a result of rebasing; and (3) it prohibits the Secretary from adjusting rebasing rates by any more than 3.5% per year.

In light of these facts, would you agree that the Secretary does in fact have flexibility in setting the rebasing adjustment and is not required to set it at the maximum level of 3.5%?

Answer: Section 3131(a) of the Affordable Care Act mandates that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that this rebasing must be phased-in over a four-year period in equal increments, not to exceed 3.5 percent The rebasing must be fully implemented by CY 2017. In the proposed rule, we did an extensive analysis of cost report and claims data. We found that the difference between average payment and cost per episode for 2013 was -13.63 percent. Phasing in the -13.63 percent over four years in equal increments would result in an annual reduction of

3.60 percent; therefore we proposed to reduce payment in each year from CYs 2014-2017 by 3.5 percent because, as required by the Affordable Care Act, the reduction may be no more than 3.5 percent. We are soliciting comments on our proposal and will make a final decision to be published in the final rule by November 1, 2013.

33. Several states' Attorneys General have expressed concern that the privacy of new customers in the health insurance exchanges under PPACA is not adequately protected in the new health insurance exchanges. The worry is that navigators and other organizations that would assist consumers are not being adequately trained to protect data. In a recent letter to the Secretary, the Attorneys General stated that, "your agency's current guidance regarding these groups suffers numerous deficiencies."

How are you guaranteeing the private medical data collected on consumers for the new health exchanges is protected against fraud?

Answer: The single, streamlined application does not collect personal health information, except from consumers seeking Medicaid coverage who need to provide information about pregnancy status and disability status in order to receive a determination of Medicaid eligibility, and the tobacco use status from consumers seeking private insurance. Applications for private health insurance available through the Marketplace are no longer permitted to seek information about a consumer's health history in light of the Affordable Care Act's market reforms.

The privacy and security of consumer data included in the single, streamlined application is a top priority for CMS and our Federal, state, and private partners. When processing these applications through the Federally-facilitated Marketplace (FFM) and the Data Services Hub, CMS will use appropriate policies, procedures, standards and implementation specifications to ensure the privacy and security of consumer data in accordance with applicable law. CMS will ensure that the IT used for the Marketplaces comply with applicable Federal laws, NIST controls, and security agreements through a stringent monitoring and evaluation system. CMS has a robust security monitoring system that reviews all security events, tools, requirements, and network device logs to identify, assess, and manage vulnerabilities and threats.

In addition to the privacy safeguards of the Federal Marketplace systems themselves, the privacy of consumer information will also be protected by Navigators and others that have been approved and certified by the FFM and the State Partnership Marketplace to assist consumers in applying for and enrolling in Marketplace coverage. In the FFM and the State Partnership Marketplace, Navigators and other Marketplace-approved assistance personnel will be required to comply with the privacy and security standards applicable under the Affordable Care Act as a condition of their agreements with CMS. CMS, as the operator of the Federally-facilitated Marketplace, will be monitoring Navigators and other FFM-approved and State Partnership Marketplace-approved assistance personnel and will take appropriate action if complaints of fraud and abuse arise. Should a grantee fail to comply with the Terms and Conditions of the award, HHS, in conjunction with the Office of Acquisitions and Grant Management, will evaluate the situation and will work with the grantee to address the situation, including considering the termination of the award or other appropriate enforcement actions.

The Honorable Gus Bilirakis

34. Over 5 million people in the United States have Alzheimer's disease. Getting a timely and accurate diagnosis is an important part of addressing this disease. Leading experts, the government's own Alzheimer's website, and National Alzheimer's Plan (NAPA) have stressed the value of early and accurate diagnosis. Diagnosing Alzheimer's has long been a challenge for the medical community but new technologies are emerging that can help determine whether memory problems may be Alzheimer's or another condition.

a. Can you tell me why CMS recently issued a draft coverage decision that would deny timely access for the appropriate Medicare patients to an FDA approved diagnostic tool for detecting Alzheimer's disease?

b. Can CMS revisit this draft decision which denies coverage, and instead adopt the appropriate use guidelines developed by the Alzheimer's Association and medical experts from the Society of Nuclear Medicine and Molecular Imaging that already deters any potential overutilization?

Answer to #s 34a & 34b: The proposed decision represents an expansion of coverage rather than a denial. As such, it exemplifies our on-going efforts to review new technology to ensure timely access to innovative products that may benefit our beneficiaries, including those with Alzheimer's Disease. In October 2012, CMS opened a National Coverage Analysis (the first step in the NCD process) to reconsider a prior NCD on the use of PET scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by Eli Lilly & Company to consider coverage of PET using a new type of radiopharmaceutical approved by FDA in 2012 to image beta-amyloid plaques in certain patients being evaluated for Alzheimer's disease and other causes of cognitive decline.

To help inform this evidence review, CMS convened a meeting of the MEDCAC in January 2013. On July 3, 2013, CMS issued a proposed coverage decision, followed by a 30 day public comment period. The proposed NCD would allow Medicare coverage of beta amyloid PET scans for diagnosis of dementia and neurodegenerative disease under the process known as CED for patients enrolled in an approved clinical study. CED is used as an alternative to non-coverage for certain items and services for which CMS has determined that the best available evidence does not support unrestricted coverage. CMS' evidence-based coverage decision-making process (including use of CED) is not meant to replace or duplicate the Food and Drug Administration's determination of a product's safety and effectiveness; rather, it's designed to meet CMS' statutory obligation to ensure that Medicare covers only items and services determined to be "reasonable and necessary" for our beneficiaries.

CMS received 202 public comments on the proposed NCD including many comments on whether CED is appropriate for beta amyloid PET scans. CMS will carefully consider those comments in developing a final coverage decision.

35. Although we continue to make strides in the detection of breast cancer, it still remains the most common cause of cancer among women of all races. The most recent technology advance in the field of mammography is 3D Mammography, which numerous published peer reviewed studies show 40% fewer women needing to be recalled for additional diagnostic appointments -- including ultrasounds and biopsies -- after their screening with 3D mammography. And, studies show much higher cancer detection rate -- in fact they are finding 40% more invasive cancers than conventional mammography. Two and a half years after FDA approval, with numerous published US studies with thousands of patients showing 3D as a game changer in women's health, Medicare has not set a payment code. Why has CMS not issued a code for this technology and does CMS have any plans to issue a code?

Answer: We agree that early and accurate detection of breast cancer is of extraordinary importance to women's health. Breast tomosynthesis (3D mammography) is a new screening technology that produces three-dimensional digital images and has been approved by FDA when used in conjunction with regular two-dimensional mammography. We are currently evaluating the payment for this digital mammography service, and have met twice with its manufacturer to discuss appropriate payment approaches.

36. In your testimony, you mentioned that States were in various stages of readiness when it comes to making Medicaid determination with the Health Exchanges. You stated that CMS was working on contingency plans with the states. How many and which states have submitted contingency plans to CMS? Can you provide the committee with a copy of those plans and CMS' communications with state agencies on contingency plans?

Answer: We have worked individually with each state to determine the readiness of their information technology systems based on a set of critical success factors. These factors include accepting the single streamlined application and applying modified-adjusted-gross-income-based rules to determine eligibility. States are making good progress towards meeting the requirements of a seamless enrollment system. As with any major undertaking, in the private or public sectors, CMS and States have developed mitigation plans to ensure a smooth process for transitioning into the enrollment and eligibility improvements.

37. What protections are in place for states and individuals who are improperly deemed eligible for Medicaid when they do not meet the criteria or in cases when someone is improperly deemed ineligible for Medicaid when they did meet the criteria?

Answer: The Marketplace will always check the income information submitted by individuals applying for insurance affordability programs against electronic data sources, such as tax filings from the Internal Revenue Service (IRS), Social Security benefit income data, and current wage information. If an individual reports an income that cannot be verified with our data sources, they will be asked to provide additional documentation to substantiate their current income.

When there is an inconsistency between an applicant's information and a data source, the Marketplace will notify the individual and give him or her 90 days to provide satisfactory

documentation (*e.g.*, pay stubs or immigration documentation) or otherwise resolve the inconsistency. In the meantime, the applicant will be able to enroll in Medicaid if they are otherwise eligible.

38. Could an individual have purchased a plan on the Exchange and then mid-year be required to enroll in Medicaid because their initial Medicaid eligibility determination was wrong? Would they have to repay the premium subsidy?

a. If someone did transition mid-year, does CMS have any plans to mitigate the potential harm from a break in the continuity of care for individuals that had their Medicaid eligibility assessed improperly and must transition mid-year to/from Medicaid and the individual suffers from complex medical conditions?

Answer: An individual that purchases a qualified health plan through the Marketplace but is later determined to be eligible for government-sponsored minimum essential coverage, such as Medicaid, would transition to government-sponsored minimum essential coverage no earlier than the first day of the first calendar month beginning after the approval. The individual would not be liable for repayment of advanced premium tax credits received while enrolled in a qualified health plan because at the time of their enrollment in the qualified health plan the Marketplace determined the individual to not be eligible for government-sponsored minimum essential coverage.

39. As you know, the ACA implements an $8 billion tax on health insurance companies in 2014 growing to $14.3 billion in 2018. Do you think this tax will increase premiums for small businesses and individuals?

Answer: The Affordable Care Act is increasing transparency and competition among health insurance plans and driving premiums down. Consumers will have access to better coverage at a lower cost in 2014. For small businesses, the Affordable Care Act fixes the broken insurance market of the past by giving small businesses the tools and opportunities to control costs and increase value.

40. Is CMS planning to assume that Congress will prevent the scheduled SGR cuts when calculating Medicare Advantage rates for 2015 as part of the February's 45 Day Notice?

Answer: For the 2014 plan year, CMS changed our longstanding approach to the SGR when calculating the national MA growth percentage.

Given the increasing number of years in a row for which Congress enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS in response to comments determined for the 2014 plan year that it was appropriate to base our estimate on what we actually expect to happen, rather than on what would happen under current law.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth from an estimate of what would occur to the physician fee schedule for the following year under current law to an estimate of what CMS believes actually will occur to the

physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014.

We made this change to reflect the fact that the Congress has annually changed the law every year since 2003 such that the projected sustainable growth rate cut does not occur. We believe it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law.

Given the market sensitive nature of MA payment, I cannot comment on how CMS plans to address MA payment policies for the 2015 plan year. Like always, we will issue an Advance Notice in February 2014 that will include a comment period and finalize our MA payment policies in April 2014 for the 2015 plan year.

The Honorable Diana DeGette

41. Ms. Tavenner, I wanted to bring to your attention an issue of concern to me as it related to families in Colorado who will be receiving benefits from our state Exchange. I understand that the premium assistance subsidy is calculated using the second lowest cost silver plan on the Exchange. My concern is that a particular benchmark plan may or may not include pediatric dental coverage. As a result, families receiving premium assistance who wish to purchase pediatric dental benefits on the Exchange may be limited in their ability to do so.

Is this true? If yes, could you explain the reasoning as to why oral health coverage for children has been excluded from important financial assistance when we know the health and cost benefits of access to dental services?

Answer: The statute provides that the amount of premium tax credit is computed based on the second-lowest cost silver plan available to an individual in a particular rating area. IRS is responsible for the implementation of the premium tax credit under section 36B of the Internal Revenue Code ("the Code"). Final Regulations implementing section 36B of the Code were published in the Federal Register on May 23, 2012. These regulations provide that the second-lowest cost silver plan, also known as an "applicable benchmark plan" is either a self-only plan or family plan, depending on whether the applicant seeks to enroll a spouse or dependents on their plan.

In addition, section 1302(b)(4)(F) of the Affordable Care Act allows qualified health plans offered through the Marketplace to exclude coverage of the pediatric dental essential health benefits if a stand-alone dental plan is offered in that Marketplace. Because of the flexibility afforded to QHPs by statute, it is possible that some QHPs may not include pediatric dental coverage. If a qualified health plan does not include pediatric dental coverage, it may still be considered a potential "applicable benchmark plan" for purposes of computing the premium tax credit.

Individuals wishing to apply premium tax credits to the purchase of a major medical and a stand-alone dental plan may choose to purchase a lower cost silver level plan, or a bronze level plan, thereby increasing the proportion of the premium that the premium tax credit that they are eligible for will cover.

The Honorable G.K. Butterfield

42. Thank you for your testimony about the significant benefits available to states under Affordable Care Act provisions to expand Medicaid. Unfortunately states like North Carolina have governments which have taken the short-sighted and harmful approach and decided not to expand Medicaid. Is there evidence that opting out of Medicaid expansion will cost states money for uncompensated care?

Answer: As you are aware, beginning in January 2014, the Federal Government will pay 100 percent of the medical assistance costs associated with adults who are considered newly-eligible in the Medicaid program. The Federal Government will continue to pay 100 percent of these costs in 2015 and 2016 as well, with the percentage of the Federal share declining to 90 percent in 2020 where it will remain in perpetuity. In fact an independent state-specific report showed the potential for significant cost savings from the reduction in uncompensated medical care.[4] We believe that this remains a good deal for states and offers the opportunity for states to expand affordable health insurance to their low-income residents while significantly reducing uncompensated care.

If North Carolina does not expand Medicaid, the state will experience a smaller drop in the number of uninsured than envisioned when Congress passed the Affordable Care Act. Regardless of whether a state decides to offer Medicaid enrollment to the new adult group, the statute requires yearly aggregate reductions to states in Medicaid disproportionate share hospital payments. These payments are currently made to states, which then make payments to hospitals, to offset the costs of serving uninsured individuals. North Carolina, should it not expand, is therefore foregoing generous Federal support for Medicaid expansion at the same time that there will be less Federal support for uncompensated care.

43. Not only does states unwillingness to expand Medicaid cost money—it also means more Americans will be uninsured in 2014. In North Carolina, there are 587,000 adults who would be newly eligible for Medicaid if the state expanded. Will some North Carolinians fall between qualifying for Medicaid and qualifying for tax credits in the individual marketplaces? What will their options be for coverage?

Answer: In states that choose not to extend coverage to the new adult group, individuals at and above 100 percent of the Federal Poverty Level (FPL) may be eligible for tax credits and cost-sharing reductions to assist them in purchasing health coverage through the new Marketplaces. These tax credits and cost-sharing reductions, per the statute, are not available to individuals under 100 percent FPL. These individuals can purchase insurance through the Marketplace, but such purchase would be at the full cost and may be unaffordable for low-income families.

44. I am encouraged by the many improvements made to our health care system due to the ACA which you have shared with us today. In my district alone, 8,200 young adults have access to health insurance on their parents' plan and 7,300 seniors have saved $9.7 million on prescription drugs. And once the Marketplaces go into effect in 2014,

[4] http://www.ncjustice.org/?q=budget-and-tax/btc-brief-medicaid-expansion-transformative-and-fiscally-sustainable-policy-north

137,000 people who lack health insurance will have access to quality and affordable coverage. Has CMS observed that costs for plans in the individual markets are lower than projected by the Congressional Budget Office? Has CMS also observed that costs for small employers in small group plans are lower than those plans absent the ACA?

Answer: Yes, CMS has observed that costs for plans in the individual market are lower than projected by the Congressional Budget Office (CBO) and costs for plans in the small group market are lower than they would be absent the Affordable Care Act. A report by the HHS Assistant Secretary for Planning and Evaluation (ASPE) found that in the 11 states for which data are available, the preliminary rate for the lowest cost silver plan in the individual market in 2014 is, on average, 18 percent less expensive than the estimate based on CBO projections.[5] Additionally, five states (CO, NM, OR, VT, and WA) and the District of Columbia have released information showing that for the small group market, proposed premiums for the lowest cost silver option are estimated to be 18 percent lower than the premium a small employer would pay for similar coverage without the ACA.

45. It is also encouraging that CCIIO is also beginning to see that costs for coverage for young adults in the individual marketplaces will remain low, even though they are joining a larger pool. CCIIO has seen plans for 21-year-old, non-smokers that are approximately $90 per month, is that correct? And if I am a 21-year-old non-smoker from Rocky Mount, North Carolina and I make $25,000 a year, I can receive tax credits to help me pay that low premium cost, correct? In fact, most Americans will qualify for assistance to make their insurance affordable, is that correct?

Answer: Several states have already released rates for 2014 that provide many affordable coverage options for individuals. For example, as detailed in an ASPE report analyzing public rates in the individual market,[6] in Albuquerque, New Mexico, a 25-year-old would pay $109 per month for the lowest cost catastrophic plan, and a 25-year-old in Portland could pay $89 for a catastrophic plan. Rates vary from state to state, by issuer, and by plan level. In addition, a 21-year-old making $25,000 a year would be eligible to receive tax credits toward their premiums. CBO has projected that about 85 percent of Americans who obtain coverage through the Marketplaces will qualify for assistance to make their insurance more affordable, an estimated 20 million Americans by 2017.

46. I want to shift gears for a minute and talk about the commendable work you are doing to spread the word to the many uninsured that will benefit from the Affordable Care Act. It is clear that CMS and many states are setting up websites and networks to keep citizens informed. In states that are unwilling to tailor marketing efforts about the Affordable Care Act, like North Carolina, what is CMS doing to reach key populations like young adults? Has CMS considered working with communities of faith or educational institutions to help spread the word about the many benefits of the ACA?

Answer: The Affordable Care Act authorizes, and CMS is implementing, a variety of ways to provide outreach, education, and enrollment assistance. We are leveraging forms of assistance

[5] http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.pdf
[6] http://aspe.hhs.gov/health/reports/2013/MarketCompetitionPremiums/rb_premiums.pdf

that exist in the insurance market today, as well as new forms of assistance provided by the Affordable Care Act to help educate Americans about the options for enrolling in affordable, high quality coverage beginning on October 1, 2013.

47. The ACA also ensures that people get more value from their insurance plans and makes insurance more transparent so rates aren't increased arbitrarily. Under ACA, insurance companies have to provide justification if they wish to increase rates by 10 percent or more. Can you discuss what sort of impact this has had on the number of requests made by insurance companies to increase rates by 10 percent or more?

Answer: The Affordable Care Act is bringing an unprecedented level of scrutiny and transparency to health insurance rate increases. The law ensures that, in any state, any proposed rate increase by individual or small group market insurers at or above 10 percent will be scrutinized by independent experts to make sure it is justified. This analysis will help moderate premium hikes and lower costs for individuals, families, and businesses that buy insurance in these markets. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for unreasonable rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps allow consumers to know why they are paying higher rates.

The Affordable Care Act makes $250 million available to States to take action against insurers seeking unreasonable rate hikes. To date, 43 States and the District of Columbia are using grants provided by HHS to help them improve their oversight of proposed health insurance rate increases. State rate-review activities are paying off for consumers:

- Rhode Island's Insurance Commissioner used his rate-review authority to reduce a proposed increase by a major insurer in that State from 7.9 percent to 1.9 percent.
- Californians were saved from rate increases totaling as high as 87 percent after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent following a public outcry.
- Connecticut's Insurance Department rejected a proposed 20 percent rate hike by one of the State's major insurers.

[1] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081909.pdf; http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11001.pdf

Attachment 2—Member Requests

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Joseph A. Pitts

1. **Will the navigators and other assistants personnel be expected to properly explain cost sharing levels under the sequester?**

    a. **If not, does this mean applicants might not be aware of financial liability?**
2. **The Department has had significant time to prepare for reductions, is this information available to the public? If so, please elaborate.**

Answer to 1 & 2: Navigators and other assistance personnel will be required to assist individuals applying for Marketplace insurance affordability programs, including cost-sharing reductions. 45 CFR 155.215(b)(2)(iv) requires Navigators in Federally-facilitated Marketplaces (FFMs) and State Partnership Marketplaces to be trained on "eligibility requirements for premium tax credits and cost-sharing reductions, and the impacts of premium tax credits on the cost of premiums," such that they can explain the eligibility rules to consumers. Cost-sharing reductions are provided to qualified individuals who enroll in a qualified health plan that has a cost-sharing structure (*e.g.,* co-pays, deductibles) such that the out-of-pocket costs paid by individuals are less than under the standard qualified health plan. Cost-sharing reductions are built into a qualified health plan's structure for out-of-pocket costs.

3. **Please provide detailed information on the cost sharing subsidy program.**

Answer: Individuals and families applying for coverage through the Marketplace may choose to have the marketplace determine whether they are eligible for any financial assistance including premium tax credits and cost-sharing reductions. In general, individuals and families with incomes between 100 percent and 250 percent of the Federal Poverty Level (FPL) may be able lower their costs for out-of-pocket expenses such as deductibles, copayments and coinsurance. The level of cost-sharing reductions depends on household income and plan design.

Any individual or family that is determined eligible for a cost-sharing reduction based on their income would have to enroll in a silver plan in the Marketplace to benefit from the cost-sharing reduction. The law also contains special provisions that eliminate cost-sharing for American Indians and Alaska Natives with incomes below 300 percent FPL and for essential health benefits for American Indians and Alaska Natives when such services are delivered through the Indian Health Service (IHS), and Indian Tribe, Tribal Organization, Urban Indian Organization or through referral under contract health services. These "plan variations" are variations of silver level plans that have their cost-sharing features modified to reflect a higher actuarial value (AV) than a standard silver plan, which has a 70 percent AV. For example, individuals with incomes between 100-150 percent FPL will enroll in a plan variation with an AV of 94 percent, those

with incomes between 150-200 percent FPL will enroll in plans with an AV of 87 percent, and those with incomes between 200-250 percent FPL will enroll in plans with an AV of 73 percent.

The statute also specifies that in order to achieve these relevant actuarial values, plans must first reduce the out of pocket maximum for essential health benefits. So, for example, individuals between 100-200 percent FPL will automatically have their out of pocket maximum reduced by two-thirds to $2250 for plan year 2014. Details regarding these figures and plan variations can be found in the *HHS Notice of Benefit and Payment Parameters for 2014*, published in the Federal Register on March 11, 2013.

4. Has CMS conducted live testing involving all parties responsible for implementation? If so, please elaborate.

Answer: The majority of states and Federal Agencies have engaged in successful live testing with the Hub. CMS began testing in October 2012 with the Internal Revenue Service (IRS); in May 2013 with the Social Security Administration (SSA), Department of Homeland Security (DHS), Department of Veterans Affairs (VA), and Peace Corps; and in July 2013 with the Office of Personnel Management (OPM) and the Department of Defense (DOD). CMS has also begun connectivity testing with a limited number of issuers.

5. What vulnerabilities have the live end testing revealed?

Answer: The Hub has gone through extensive testing and testing will continue to ensure it is compliant with applicable FISMA and NIST security standards.

6. Please have HHS provide any reports, audits, or work plans to show the contractors work.

Answer: We will work with your staff to provide this information.

The Honorable Lee Terry

7. Please provide the Committee with the schedule of live testing for the data hub with all of the federal agencies.

Answer: CMS began testing in October 2012 with IRS; in May 2013 with SSA, DHS, VA, and Peace Corps; and in July 2013 with OPM and DOD. Testing will continue after the system goes live on October 1, 2013.

8. How much money has HHS paid United/QSSI to date on the data hub contract?

Answer: CMS has paid QSSI $45 million to date in support of the Data Services Hub contract.

The Honorable Michael C. Burgess

9. Who informed your chief of staff about the employer mandate delay? Please elaborate.

Answer: My Chief of Staff learned of the delay when she attended a meeting in June 2013.

The Honorable Leonard Lance

10. Please explain where New Jersey stands with regards to the Medicaid application process.

Answer: CMS developed a single, streamlined application for use in assessing eligibility for Marketplace coverage, Medicaid, and the Children's Health Insurance Program (CHIP). States have the option of using the model application or developing an alternative application. We have been meeting regularly with states, including New Jersey, to provide technical assistance to facilitate either the adoption of the model application or throughout the development of an alternative application.

The Honorable Bill Cassidy

11. Please explain to the Committee how CMS is individually working for each state based exchange regarding attestation.

Answer: Marketplaces will always use data from tax filings from IRS and Social Security benefit income data to verify household income information provided on an application, and in many cases, will also use current wage information that is available electronically. The multi-step process begins when an individual applies for insurance affordability programs (including advance payments of the premium tax credit and cost-sharing reductions) through the Marketplace and affirms or inputs their projected annual household income. The inputted income is then compared with information available from IRS and SSA. If the information submitted cannot be verified using IRS and SSA data, then it is compared with wage information from employers provided by Equifax. If Equifax data does not substantiate the inputted information, the Marketplace will request an explanation or additional documentation to substantiate the inputted income.

The Honorable Adam Kinzinger

12. How many agencies are involved with implementing the Affordable Care Act?

Answer: Below is a list of the participating Federal Departments and executive agencies or operating divisions assisting, in various capacities and consistent with their individual mission and authorities, with implementing the Affordable Care Act:

- U.S. Department of Agriculture
- Department of Commerce
  - Census Bureau
- DOD (Tricare)
- Department of Education
- HHS
  - Office of the Secretary
  - CMS
  - Health Resources and Services Administration (HRSA)
  - IHS
  - Substance Abuse and Mental Health Services Administration
  - Centers for Disease Control and Prevention
  - Agency for Healthcare Research and Quality
- DHS
- HUD
- Department of Justice
- Department of Labor
- Department of State
- Department of Transportation
- Department of the Treasury
  - IRS
- VA
- Corporation for National and Community Service
- Environmental Protection Agency
- Executive Office of the President
  - Office of Management and Budget
  - Office of National Drug Control Policy
- General Services Administration
- OPM
- Peace Corps
- Small Business Administration
- Social Security Administration
- U.S. Agency for International Development
- U.S. Postal Service
- Government Accountability Office

13. How often is there a regular interagency meeting on the implementation of the Affordable Care Act?

Answer: Inter-agency meetings on a variety of topics related to Affordable Care Act implementation are held on a regular basis.

14. Is there a deputies, or any other type of, meeting regularly convened by the White House staff on implementation of the Affordable Care Act?

Answer: Executive branch entities, including those within the Executive Office of the President, meet regularly to discuss policy issues.

15. Please submit written updates of the implementation of the Affordable Care Act that you receive within the agency.

Answer: I receive regular verbal implementation updates in meetings.

16. How much will the Affordable Care Act cost to implement (including Hub, advertising, implementation, etc.)?

Answer: Affordable Care Act responsibilities are now a part of CMS' core mission and many of the activities are supported through CMS base operations. CMS is able to breakout the costs associated with CMS' Marketplace responsibilities. In FY 2011 and FY 2012, CMS spent approximately $118 million and $304 million, respectively, on Marketplace activities from the $1 billion Implementation Fund, CMS Program Management, and the Secretary's Transfer from General Departmental Management. In FY 2013, CMS is planning to spend $1.5 billion from Program Management, the Secretary's Transfer Authority, Non-Recurring Expenses Fund, the $1 Billion Implementation Fund, and the Prevention Fund. The President's FY 2014 Budget proposed a total of $2 billion for Marketplace implementation, including $1.5 billion in appropriated funds and $450 million in user fees. Additionally, HRSA is devoting approximately $150 million in FY 2013 funding to Affordable Care Act Outreach and Enrollment efforts to benefit Health Centers and their patient populations. These efforts will facilitate enrollment of eligible health center patients and service area residents into affordable health insurance coverage through the Health Insurance Marketplaces, Medicaid or CHIP.

The Honorable Gus Bilirakis

17. Please submit your projections regarding the amount of improper payments that have been made with respect to the Affordable Care Act.

Answer: CMS measures the national payment error rate for Medicaid annually, through the Payment Error Rate Measurement (PERM) program. Through the PERM, CMS measures three areas of Medicaid and CHIP: fee-for-service (FFS) claims, managed care claims, and eligibility cases. Using CMS' guidelines, the states lead the effort in measuring errors in the eligibility cases. A sample of 17 states is measured each year to produce and report national program error rates.

The national Medicaid error rate reported for FY 2012 is 7.1 percent, or $19.2 billion in gross improper payments, which reflects a three-year weighted average national error rate including data from 2010, 2011, and 2012. The weighted national error component rates are as follows: Medicaid FFS: 3.0 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent. The FY 2012 national CHIP improper payment rate is 8.2 percent or $700 million. The national component improper payment rates are as follows: CHIP FFS: 6.9 percent; CHIP managed care: 0.1 percent; and CHIP eligibility: 5.8 percent.

In light of changes to the way states adjudicate eligibility for applicants for Medicaid starting in 2014, CMS will be implementing an annual 50-state pilot program strategy with rapid feedback for improvement, in place of the PERM eligibility reviews, starting January 1, 2014, for FYs 2014-2016. These programs will help inform CMS's approach to rulemaking that it will undertake prior to the resumption of the PERM eligibility measurement component in FY 2017. During this period, PERM managed care and fee-for-service payment reviews will continue uninterrupted on the normal cycle schedule, and CMS will continue to report Medicaid improper payment rates based on that data. In addition, CMS will continue to report comprehensive Medicaid error rates in FYs 2015, 2016, and 2017 based on the FFS and managed care PERM reviews and an estimated eligibility component rate based on historical data.

The Honorable Rene Ellmers

18. The rule that came out on January 22, 2013, reporting under Section 6055 and 6056 of the code, said that the employer mandate could contribute to the integrity of employer verification into the future. Is this correct?

Answer: Yes, the Proposed Rule said that "reporting under sections 6055 and 6056 of the Code will not begin until 2015, although it is anticipated that this reporting could greatly contribute to the integrity of employer verification in the future."[1]

19. Please provide the Committee with information on the income verification process.

Answer: The Marketplace will always check the income information submitted by individuals applying for insurance affordability programs against electronic data sources, such as tax filings from IRS, Social Security benefit income data, and current wage information. When there is an inconsistency between the income information to which an applicant attests and that contained in an electronic data source, the Marketplace will notify the individual and provide her with 90 days to provide satisfactory documentation (*e.g.*, pay stubs) or otherwise resolve the inconsistency. In the meantime, the applicant will be able to enroll in a qualified health plan with an advanced premium tax credit or a cost-sharing reduction, if the applicant is otherwise eligible. If an individual reports an income that cannot be verified with our data sources, they will be asked to provide additional documentation to substantiate their current income. Any applicant receiving a tax credit must file a tax return the next year.

[1] The full text of the rule is available at http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/html/2013-00659.htm.

The Honorable John D. Dingell

20. Will the new health insurance marketplaces be up and running for open enrollment as scheduled 60 days from now? If so, please elaborate on how the different states will be ready for open enrollment.

Answer: Yes, the new health insurance Marketplaces will be up and running for open enrollment as scheduled 60 days from now. Some states will have FFMs, relying on the Federal Government to establish and operate a marketplace in the state. Other states are partnering with the Federal Government to operate a marketplace. For these states, CMS has already completed the majority of the development of the services required to support open enrollment beginning on October 1, 2013 for coverage starting January 1, 2014.

21. Please provide the Committee with a paragraph explaining if the decision to delay the employer mandate impacts the timetable for the implementation of the Affordable Care Act. If so, how?

Answer: Numerous experts agree that the delay of the employer shared responsibility provisions will have little impact on the overall implementation of the law, mainly because about 96 percent of employers with more than 50 workers already provide insurance. The one-year delay in the application of the employer shared responsibility provision does not have a large operational impact on Affordable Care Act implementation, and does not affect the law's overall goals.

22. Would you please elaborate on how consumers across the country will reap the benefits of increased competition through lower rates?

Answer: We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. While many states are still finalizing or finishing final review of their rates, some, like New York, California, Washington, Vermont, Oregon, and the District of Columbia, have released preliminary rates, and in some cases, independent experts say that these rates have been lower than expected. In the eleven states for which data are available, the preliminary rate for the lowest cost silver plan in the individual market in 2014 is, on average, 18 percent less expensive than the estimate based on CBO projections.

This is good news for consumers. In fact, some states have released initial bids only to have insurers request to amend their bid after competitors' publically-available bids come in at lower prices. In Washington, D.C., United Health Care and Aetna both reduced their small group rates, by 10 percent and 5 percent, respectively. In Oregon, two plans requested to lower their rates by 15 percent or more. Some rates submitted to California's Marketplace, Covered California, are as much as 29 percent below the 2013 average premiums for small employer plans in California's most populous regions. New York State has said on average, the approved 2014 rates for even the highest levels of coverage of plans individual consumers can purchase on New York's Health Benefits Exchange (gold and platinum) represent a 53-percent reduction compared to last year's direct-pay individual rates. Furthermore, states are using their rate-review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for

some plans by as much as 35 percent, offering consumers an even better deal on their coverage for the 2014 plan year.

23. Please submit your comments on Americans saving money due to the rate review provision and how the average premium increase was 30 percent less in 2012 than it was in 2010.

Answer: The Affordable Care Act is bringing an unprecedented level of scrutiny and transparency to health insurance rate increases. The law ensures that, in any state, any proposed rate increase by individual or small group market insurers at or above 10 percent will be scrutinized by independent experts to make sure it is justified. This analysis will help moderate premium hikes and lower costs for individuals, families, and businesses that buy insurance in these markets. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for unreasonable rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps allow consumers to know why they are paying higher rates.

The Affordable Care Act makes $250 million available to States to take action against insurers seeking unreasonable rate hikes. To date, 43 States and the District of Columbia are using grants provided by HHS to help them improve their oversight of proposed health insurance rate increases. State rate-review activities are paying off for consumers:

- Rhode Island's Insurance Commissioner used his rate-review authority to reduce a proposed increase by a major insurer in that State from 7.9 percent to 1.9 percent.
- Californians were saved from rate increases totaling as high as 87 percent after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent following a public outcry.
- Connecticut's Insurance Department rejected a proposed 20 percent rate hike by one of the State's major insurers.

24. Please provide the Committee with a summary of potential trends in the future regarding the average premium decreases.

Answer: We are already seeing evidence that the Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. While many states are still finalizing or finishing final review of their rates, some, like New York, California, Washington, Vermont, Oregon, and the District of Columbia, have released preliminary rates, and in some cases, independent experts say that these rates have been lower than expected. In the eleven states for which data are available, the preliminary rate for the lowest cost silver plan in the individual market in 2014 is, on average, 18 percent less expensive than the estimate based on CBO projections.

This is good news for consumers. In fact, some states have released initial bids only to have insurers request to amend their bid after competitors' publically-available bids come in at lower

prices. In Washington, D.C., United Health Care and Aetna both reduced their small group rates, by 10 percent and 5 percent, respectively. In Oregon, two plans requested to lower their rates by 15 percent or more. Some rates submitted to California's Marketplace, Covered California, are as much as 29 percent below the 2013 average premiums for small employer plans in California's most populous regions. New York State has said on average, the approved 2014 rates for even the highest levels of coverage of plans individual consumers can purchase on New York's Health Benefits Exchange (gold and platinum) represent a 53-percent reduction compared to last year's direct-pay individual rates. Furthermore, states are using their rate review powers to review and adjust rates accordingly. In Oregon, the state has reduced rates for some plans by as much as 35 percent, offering consumers an even better deal on their coverage for the 2014 plan year.

The Honorable Diana DeGette

25. Please provide the Committee with a paragraph describing what the agency is doing to ensure consumer privacy.

Answer: The protection of consumer privacy is a high priority for CMS in the implementation of the Marketplace and strict security and privacy standards govern the Marketplace information technology (IT) systems. The Congress acknowledged the importance of protecting personal information through the Privacy Act of 1974, which establishes requirements that govern the collection, use, and disclosure of information about individuals that is maintained by a Federal executive agency in a "system of records." Since then, the Congress has passed amendments to the Privacy Act and additional legislation to assure Americans that information collected, created, used, and disclosed by Federal agencies is appropriately safeguarded. These additional protections include the Computer Matching and Privacy Protection Act, which amended the Privacy Act, and the e-Government Act of 2002. IT projects undertaken by Federal Agencies and their contractors in support of the Affordable Care Act will comply with these and all other applicable Federal laws, so that the American public is assured that their personal information is protected.

Additionally, certain classes of data may be subject to additional restrictions or protection on data use or transmission. For example, information systems containing tax return information must also comply with the taxpayer privacy and safeguards requirements of section 6103 of the Internal Revenue Code.

In order to establish controls and checkpoints within the Marketplace IT systems, CMS established a series of agreements, business processes, and protocols to ensure privacy controls have been met. Because the databases connected to the Marketplace eligibility systems by the Hub are secure and closed government databases that already exist and comply with Federal privacy standards, most of the work of implementing privacy controls is conducted through business agreements between CMS and its Federal and state partners to assure data is being handled appropriately by all parties before data is exchanged through the Hub. To fulfill the Computer Matching and Privacy Protection Act requirements, CMS is establishing Computer Matching Agreements between CMS and each Federal and state partner. These agreements describe how each partner will exchange information, using the Hub, in a way that ensures the privacy, integrity, and verification of data disclosed during this exchange. CMS and our Federal partners have signed additional agreements about the use of data and information exchanges, as applicable. CMS began formalizing these processes with our partners in July 2011, and has refined and updated them as the Marketplace IT work has progressed.

To ensure these agreements are met, CMS conducts Privacy Impact Assessments. Before State-based Marketplaces are able to use the Hub, CMS conducts a Privacy Impact Assessment to ensure that the State-based Marketplace has met all Federal privacy requirements. CMS is currently reviewing the State-based Marketplaces' Privacy Impact Assessments. Before the Hub is used to route information from Federal databases to Marketplace eligibility systems, CMS completes Federal Privacy Impact Assessments to ensure this information exchange meets the agreed-upon privacy requirements.